C+D

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14 March 2009

What are you worth?

The Salary Survey results revealed...

See pages 4-5

Earnings up despite recession

But rises were modest in the last 12 months, with bonuses cut and dissatisfaction growing

Zoe Smeaton

Most employed pharmacists have enjoyed pay rises in the last 12 months despite the bleak economic climate, the C+D and PDA Union Salary Survey has found.

But the rises were modest, bonuses have been cut, and 47 per cent of pharmacists remain dissatisfied with their pay.

The average salary for an employed pharmacist was £38,402 this year, up 4 per cent from £36,920 last year. Contracted hours varied.

And two-thirds of the 500-plus employed pharmacist respondents said they had received a pay rise, the survey revealed.

Almost 40 per cent of pharmacists said they had received a bonus in 2008, but only 11 per cent of pharmacists felt they were being paid the right amount.

A spokesperson for the Federation of Small Businesses said it was encouraging to see people being offered pay rises when many employers had been forced to cut staff hours or make people redundant.

Mani Butt, of Prestwich Pharmacy, said she was happy with her pay deal at the moment. She felt employees had to work a bit harder in the current climate, but said she had not been affected financially.

And Bobby Mehta at the Alliance Pharmacy in Burnham said he felt pharmacy had been reasonably well buffered from the economic crisis relative to some industries. But he warned it was hard to predict what the next year would bring. "That's the million dollar question as it looks like things will get worse before they get better," he said.

Are you happy with your pay?
zsmeaton@cmpmedica.com

Salary survey at a glance

£38,402
Average salary for employed pharmacist

£1,482
Average pay rise for employed pharmacist over last 12 months

47 per cent
Proportion of employed pharmacists unhappy with their pay

Contractors hurting but up pay

Contractors bore the brunt of adverse financial impacts on independent pharmacies last year but many gave staff pay rises despite falling profits.

Sixty per cent saw income decrease in 2008, the C+D and PDA Union Salary Survey found.

Half were forced to cut their own pay, but almost two-thirds still managed to give staff pay rises, a snapshot of 44 independent contractors revealed.

And, despite redundancies caused by category M clawbacks reported in C+D, three-quarters of survey respondents had not let any staff go.

IPF chairman Fin McCaul said he was astounded more contractors hadn't seen income fall. But he added the seemingly surprising staff wage increases could reflect that most would have been awarded in April, before the impact of category M and the credit crunch were realised.

"The cat M stuff only hit in January – it took most people six months to realise how bad it was," Mr McCaul said. "Because of the current credit crunch, this year they would be much less likely to have pay rises."

One contractor said he had awarded pay rises "at my own cost to ensure staff morale stays high".

After cutting their own pay, contractors were most likely to have dealt with the hostile financial climate by postponing improvement plans and cutting staff hours, the survey showed. **JR**

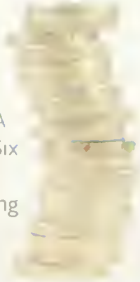
£ Salary bites ... £ Salary bites ... £ Salary bites ... £ Salary bites ...

What credit crunch?

Job cuts, pay freezes, there's no escaping the credit crunch, unless you work as an employed pharmacist. Almost seven out of 10 bosses [illegible] the last year with three out of 10 also cutting [illegible]

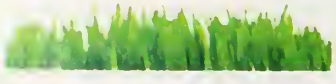
Premier league pay

A handful of employed pharmacists earn over £70,000 a year, says the C+D and PDA Union salary survey. Six people reported pay packets to rival banking chiefs and premier league football stars



Grass not always greener

The flexible life of a locum is often the envy of employed pharmacists. But our survey found over half of locums had no rise in rates last year. Thirteen respondents were so fed up they planned to quit and become employed pharmacists.



Perk me up

Top perks for employed pharmacists:
1. RPSGB fees paid
2. Instore discounts
3. Pensions

Least common perks:
1. Private dental care
2. Gym memberships
3. Cheap car loans

Locum pay down £1.7k

Hourly rates have dropped across the country, except for those in the north east

Chris Chapman

Annual locum earnings have plummeted an average £1,700 over the past year, the C+D and PDA Union Salary Survey has revealed.

Hourly rates dropped across the country, findings showed, with only pharmacists in north east England better off than in 2007-08.

London was the worst-hit area, with locums in the capital down nearly £5,000 this year.

Nationally, just 43 per cent of 340 locums reported an increase in wages during the past 12 months.

The average rate locums could negotiate was around £23 per hour – a pound less than at this time last year. Forty six per cent of respondents said they were dissatisfied with hourly rates.

Locums worked an average of 33 hours per week, the survey found.

Lindsey Gilpin, a locum pharmacist, said that while she recognised budgets were tight, she found the results "very disappointing" considering the additional roles locums were now required to take on.

She said: "One does realise that it's difficult economic times, and that category M has rattled through the whole of pharmacy. But it's very disappointing, I think, especially considering we are now doing so much more."

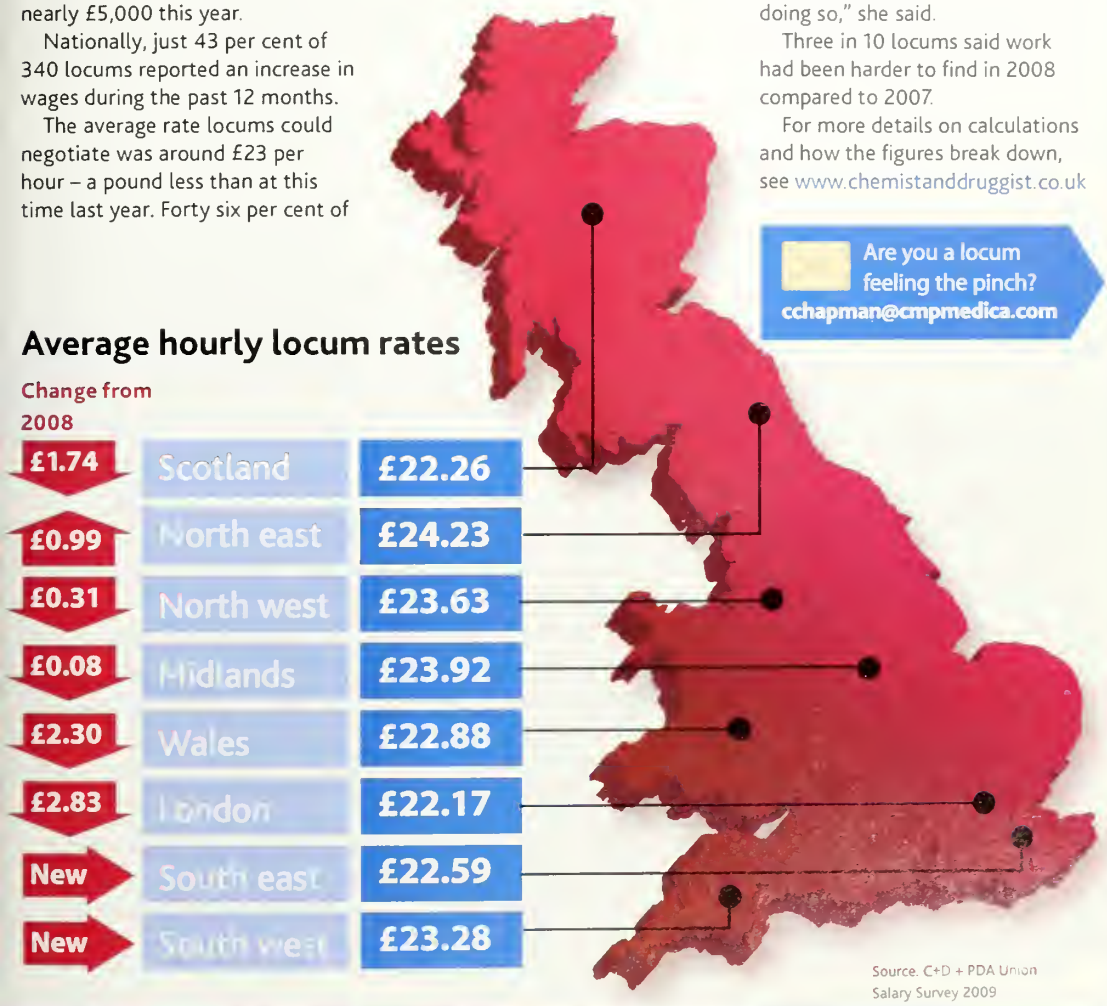
But locum Catherine Armstrong said: "I can understand rates decreasing in this economic climate, and I haven't increased rates because I would feel guilty doing so," she said.

Three in 10 locums said work had been harder to find in 2008 compared to 2007.

For more details on calculations and how the figures break down, see www.chemistanddruggist.co.uk

Are you a locum feeling the pinch?
cchapman@cmpmedica.com

Average hourly locum rates



Source: C+D + PDA Union Salary Survey 2009

Salary TALK

"I'm quite happy. I'm as secure as anyone can be in their job at the moment."
Mani Butt, employee, Prestwich Pharmacy, Manchester

"We have seen a decrease of about 6 per cent in gross profit, which is a severe drop because it's straight off the bottom line."
Vinod Patel, contractor, Bradshaw Street Pharmacy, Wigan

"We've not felt the problems as much as other sectors so there is relative satisfaction, although people always want more."
Bobby Mehta, employee, Alliance Pharmacy, Burnham

"That's nothing unusual – it's not a nine-to-five job."
Fin McCaul, IPF chairman, on the 50-plus hours per week worked by 60 per cent of contractors.

"Some employees are unaware of the effects category M and other financial pressures are having on pharmacy, so they perceive their jobs to be secure."
Asif Khan, independent contractor, Barnsley

"We have given staff a pay rise and recruited more as well, because of the work we're doing, so we're lucky in that respect, but how long we can sustain that we don't know."
Amit Shah, contractor, Bees Pharmacy, London

£ Salary bites ... £ Salary bites ... £ Salary bites

...and finally:

14,629
The average technician's salary in pounds for a 31-hour week

87
Percentage of employed pharmacists who get no bonus for doing MURs

20
Pounds or less – the best standard hourly rate reported by 16 per cent of locums

79
The maximum number of [illegible] a week worked by one pharmacy owner

See more
[illegible]druggist.
[illegible]rvey
Job satisfaction and morale

Vaccine still effective

Women previously exposed to HPV can still benefit from vaccination, a study has found. Women aged 16 to 26 showed reduced rates of precancerous cervical lesions after vaccination with Gardasil, regardless of prior exposure to HPV.

GPs fail with eczema

Almost nine out of 10 GPs are too busy to advise patients on how to treat eczema, a survey has shown. The poll of 200 GPs, by the manufacturer of Oilatum, found parents often do not receive written information or demonstrations of how to apply emollients.

NCSO update

The Department of Health and National Assembly for Wales have agreed to allow NCSO endorsements for the following items for March prescriptions: cimetidine 200mg tablets, cimetidine 400mg tablets and hydroxyzine 25mg tablets.

Technician regulation

The compulsory regulation of all UK pharmacy technicians came a step closer this week, as draft legislation was laid before the Scottish and Westminster Parliaments. The RPSGB backed the proposals in the Healthcare and Associated Professions Order 2009, which could come into force by this summer

Scottish CPP

Scottish contractors must complete an audit of interventions made in dispensing NHS prescriptions next week (March 16 to 22), in order to qualify for contract preparation payments of £900. Guidance is available at www.communitypharmacyscotland.org.uk. The audit will guide the introduction of the Scottish contract's chronic medication service.

Bowel cancer campaign

Pharmacists will be asked to raise awareness of bowel cancer next month. Bowel Cancer UK plans a Check It initiative in [illegible] to help catch early cases of [illegible]. The move coincides [illegible] bowel cancer [illegible]

Exporters are sullying sector, warns PSNC

Medicines supply in for 'turbulent year' as strong euro tempts contractors to export

Chris Chapman

Contractors who parallel export medicines are ruining the reputation of the profession, PSNC's chief executive warned the LPC conference this week.

In her opening address, Sue Sharpe said the potential damage to pharmacy's standing caused by medicine exports was "immense".

She said: "Any contractor who diverts supplies intended for UK patients elsewhere could contribute to damaging our standing."

Ms Sharpe warned of a "turbulent year" for medicines supply, as the falling value of the pound against the euro drove exports and tempted contractors.

She said: "Contractors large and small get offers to buy quantities large and small of targeted medicines. The trade has

Sue Sharpe: pharmacy's reputation is in danger

driven shortages in UK stocks."

PSNC "strongly disapproved" of any trade that made contractors' roles more difficult, she added.

Ms Sharpe also said supply problems were also exacerbated by manufacturer supply deals.

She commented: "We have seen more and more manufacturers introduce new distribution arrangements for their products. This is in large part a reflection of their wish to control stocks and manage supplies, so it adds yet more burden on pharmacy contractors."

PSNC was not able to dictate wholesale supply arrangements, she added.

The comments came as delegates gathered at the Lancaster Hotel in London for the annual conference.

LPCs were due to debate 16 resolutions on topics including prescription switching, manufacturer-led distribution deals and 100-hour pharmacies.

Resolutions included a call for PSNC to seek compensation for pharmacies forced to close by polyclinics (Kingston, Richmond and Twickenham LPC).

See next week's C+D for full coverage of the conference.

Thousands of scripts go missing in transit

PSNC has defended the sector as government figures revealed tens of thousands of prescriptions went missing in transit from community pharmacies in England to NHS paymasters last year.

Almost 46,000 prescriptions went missing en route to NHS Prescription Services (formerly the PPD) during 2007-08, it was revealed in answer to a parliamentary question last week.

PSNC defended pharmacies in relation to the losses, saying that a change to the Drug Tariff last year required them to despatch prescriptions "in a secure manner that enable tracking and tracing of delivery".

There was always a risk of breach of couriers' security, PSNC added, but it emphasised pharmacy's commitment to minimising this. "Pharmacists understand the importance of the information they are posting off," PSNC said, "and, of course, the financial importance of it to themselves as well."

However, the contract negotiator also issued a "timely reminder" to contractors to ensure the secure delivery of scripts.

The 2007-08 figure was 50 per cent more than the previous financial year, and numbers look set to rise further for 2008-09, as more than 46,000 prescriptions were lost between April and November last year alone.

The Conservatives attacked the government for failing to protect patient data in the scripts, but the Department of Health said 99.9 per cent made the journey safely.

Prescription Services estimate contractors' payments in the event of loss, in agreement with the local PCT. "PSNC can provide support to pharmacy contractors in negotiating payment in this situation," the contract negotiator said. **JR**

Have your scripts gone missing in transit?
jrichardson@cmpmedica.com

Fresh calls to abolish Rx charge

Community pharmacy has issued fresh calls for the abolition of prescription charges in England, after the government announced a fee increase of 10p per item.

From April 1, the prescription charge in England will be raised from £7.10 to £7.20, the DH announced last week.

The NPA and the Co-operative Pharmacy both reacted by calling for abolition of the charge, in line with the devolved home nations.

NPA chief executive John Turk said this would "improve access to medicines, remove inequalities and decrease the administrative burden on community pharmacies".

The scrapping of the fee should be linked to the introduction of a national pharmacy minor ailments service, the NPA added.

John Nuttall, managing director of Co-operative Pharmacy, said debate was needed "more than ever, to discuss why England is being penalised over prescriptions". **JR**

New

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fluticasone furoate

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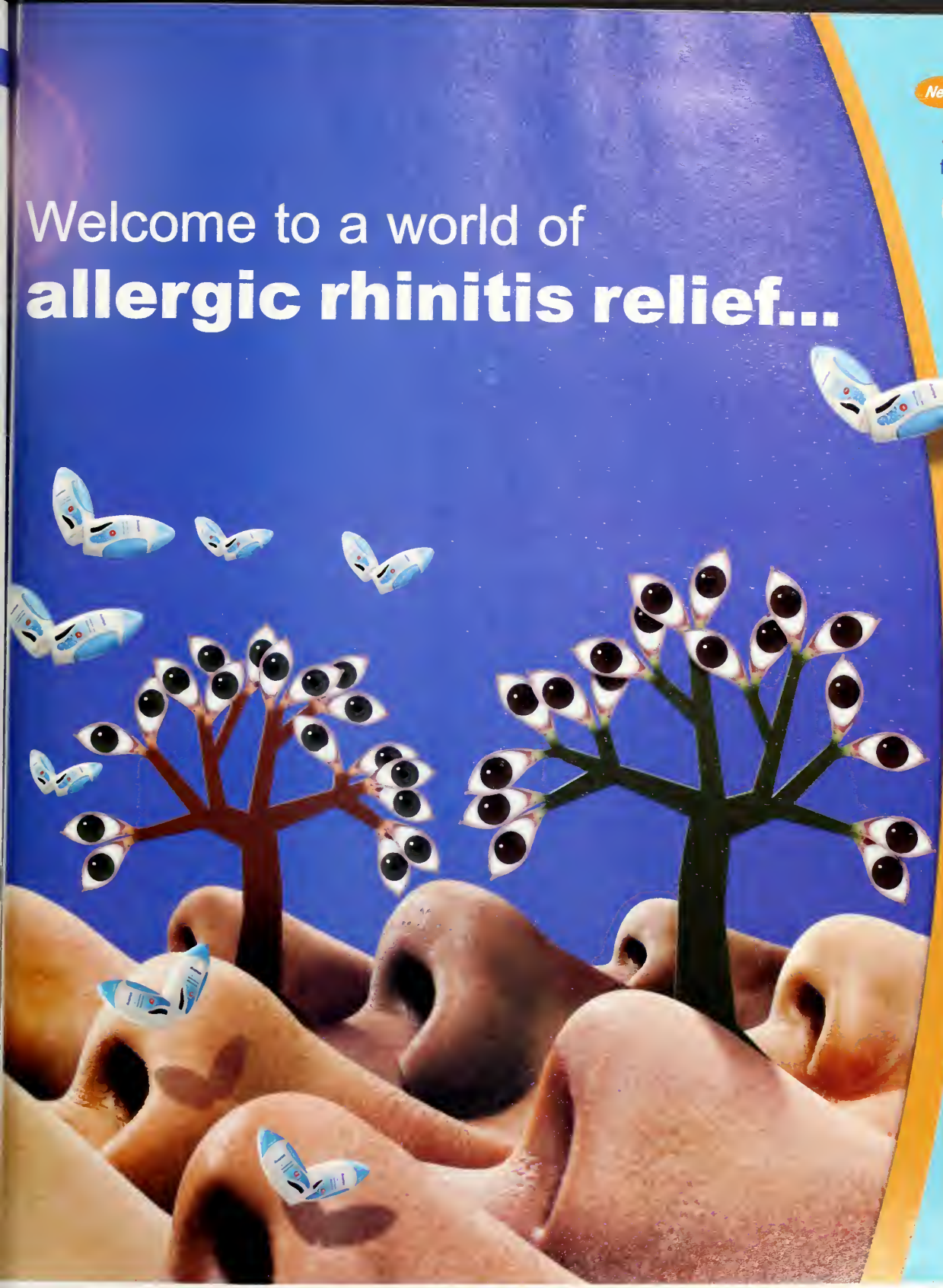
Welcome to a world of **allergic rhinitis relief...**



Avamys is a new intranasal steroid providing relief from both nasal and ocular seasonal allergic rhinitis symptoms.[1]

It's a once daily therapy[4] available in an award winning device.[5]

Prescribing Information
(Please refer to the full Summary of Product Characteristics before prescribing)
Avamys®▼ Nasal Spray Suspension (fluticasone furoate 27.5 micrograms /metered spray) Uses: Treatment of symptoms of allergic rhinitis in adults and children aged 6 years and over. **Dosage and Administration:** For intranasal use only. *Adults:* Two sprays per nostril once daily (total daily dose, 110 micrograms). Once symptoms controlled, use maintenance dose of one spray per nostril once daily (total daily dose, 55 micrograms). *Children aged 6 to 11 years:* One spray per nostril once daily (total daily dose, 55 micrograms). If patient is not adequately responding, increase daily dose to 110 micrograms (two sprays per nostril, once daily) and reduce back down to 55 microgram daily dose once control is achieved. **Contraindication:** Hypersensitivity to active ingredients or excipients. **Side Effects:** *Common:* nasal ulceration. *Very common:* epistaxis. Epistaxis was generally mild to moderate, with incidences in adults and adolescents higher in longer-term use (more than 6 weeks). **Precautions:** Systemic effects of nasal corticosteroids may occur, particularly when prescribed at high doses for prolonged periods. Treatment with higher than recommended doses may result in clinically significant adrenal suppression. Consider additional systemic corticosteroid cover during periods of stress or elective surgery. Caution when prescribing concurrently with other corticosteroids. Growth retardation has been reported in children receiving some nasal corticosteroids at licensed doses. Monitor height of children. Reduce to lowest dose at which effective control of symptoms is maintained or refer to paediatric specialist. May cause irritation of the nasal mucosa. Caution when treating patients with severe liver disease, systemic exposure likely to be increased. **Pregnancy and Lactation:** No adequate data available. Recommended nasal doses result in minimal systemic exposure. It is unknown if fluticasone furoate nasal spray is excreted in breast milk. Only use if the expected benefits to the mother outweigh the possible risks to the child. **Drug interactions:** Caution is recommended when co-administering with inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole and ritonavir. **Presentation and Basic NHS cost:** Avamys Nasal Spray Suspension: 120 sprays £6.44 **Market Authorisation number:** EU/1/07/434/003 **Legal category:** POM. PL holder: Glaxo Group Ltd, Greenford, Middlesex, UB6 0NN, United Kingdom. **Last date of revision:** December 2008

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to GlaxoSmithKline on 0800 221 441.

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References:
1. Fokkens WJ, Jogi R, Reinartz S *et al.* Once daily fluticasone furoate nasal spray is effective in seasonal allergic rhinitis caused by grass pollen. *Allergy* 2007; 62: 1077–1084.
2. Kaiser HB, Naclerio RM, Given J *et al.* Fluticasone furoate nasal spray: a single treatment option for the symptoms of seasonal allergic rhinitis. *J Allergy Clin Immunol* 2007; 119: 1423–1427.
3. Robert P Ambrey [illegible]

[illegible] based upon [illegible] petition operators [illegible] made and did not test [illegible] ination please visit

[illegible] 2009.

Date of preparation: January 2009

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Dispensary TALK

How do you feel about the RPSGB spend on staff events?

"With the current credit crunch it's essential that all public bodies are transparent in everything they do. And if they can justify the money spent that's fine. But it has to be justifiable... and I have a gut feeling that they may have difficulty justifying this amount."
Michael Maguire, Marton Pharmacy, Middlesbrough

"They must be a very generous employer if they're spending that amount. I think most companies don't spend that for entertainment."
Gurminder Sall, Jeeves Chemist, Buckinghamshire

WEB VERDICT:

It's not a problem	25%
I have no opinion	12%
I strongly object	63%

Armchair view: Respondents [illegible] and barbeques – at least [illegible] membership fees are [illegible] the bill.
Next week's question: Who has suffered most from pharmacies' reduced income? Vote at www.chemistanddruggist.co.uk

Restrict 'pharmacist' title, RPSGB suggests

Society urges GPhC to keep both practising and non-practising registers

Chris Chapman

Members of the profession must be on the GPhC's registers to use the title 'pharmacist', the RPSGB has recommended in its response to the Section 60 Order.

The Society urged the GPhC to keep both practising and non-practising registers. Those on either register would be entitled to call themselves a pharmacist.

Those who did not register with the GPhC should only be allowed to use 'former pharmacist' or 'retired pharmacist', the Society advised.

Speaking exclusively to C+D, RPSGB president Steve Churton said the Society had tried to "maintain the status quo" and had listened to members of the profession.

At present, it is against the law for anyone not on the RPSGB register to use the title 'pharmacist' – including those who have retired from the profession.

Mr Churton said his comments were aimed to clear the "myths" and "misinformation" clouding the issue.

Steve Churton: unrestricted title would dilute confidence in profession

However, Buckinghamshire pharmacist John Rees warned that retired pharmacists would continue to be "disenfranchised" by the decision, calling the Society's recommendations a "dereliction of its duty".

Mr Churton said not restricting the title to those on the registers would "open the floodgates" and dilute patients' confidence in the profession.

He said: "If you go around calling yourself a pharmacist people believe you are fit to practise... if the title becomes unrestricted it could be used by anybody."

The DH consultation on the Section 60 Order, which sets out the roles, functions and powers of the regulatory body, ended this week.

The government aims to launch the new regulatory body in spring 2010.

What's in a name?

What you would be called if the Society's proposals are adopted:
On the GPhC practising register: pharmacist
On the GPhC non-practising register: non-practising pharmacist, making it clear you are non-practising
Not on the GPhC register but have been on the register previously: 'Former pharmacist' or 'retired pharmacist', as appropriate.

The immediate past president of the RPSGB, Hemant Patel, pictured, is seeking election to the English Pharmacy Board (EPB) in the Society's 2009 elections. Candidates standing for Council and the Scottish and Welsh Pharmacy Boards have also been announced, and voting papers will be posted to Society members at the beginning of next month. Mr Patel is up against current EPB chair Beth Taylor, current member Gail Curphey and former Council member Graham Phillips for one of two unreserved places on the EPB. Mr Patel told C+D he was inspired to stand by the white paper, published just one month before his third term as president came to an end last May. "If properly guided, that could enable us to develop a pharmacy system that's the envy of the world," Mr Patel said, "but it requires a lot of planning and understanding of how to bring about change." For more information on Council and devolved board candidates, see www.chemistanddruggist.co.uk

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* Pet accessories and healthcare market intelligence, Mintel, Sept 2008.
** Gfk – UK companion animal ectoparasiticide market, Dec 2008.
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Breaking point?

Is lunch for wimps or an essential time to recharge the batteries? According to the latest research from the PDA, regular breaks are falling by the wayside. **Zoe Smeaton** investigates

Grabbing a sandwich in the dispensary, retreating to the consultation room but facing constant interruptions, or just going without food altogether. Whatever your tactics, if you're a community pharmacist, the chances are you don't take a proper break for lunch. In fact, it's quite likely that, on at least some days, you don't take a rest break at all.

The PDA revealed at its conference this month that only 16 per cent of employee pharmacists and 12 per cent of locums take regular breaks. And the trend seems to extend to pharmacy owners, as all contractors asked by C+D say they never take lunch breaks.

But it does seem that some people are able to work through the day without any need to pause, and in many cases choose to do so. Locums might opt to work through the day to boost their pay, and contractors to benefit their businesses. David Croucher, of Niton Pharmacy on the Isle of Wight, has never taken a lunch break in his 34 years as a community pharmacist and doesn't miss them. "It's a culture I have grown up with... we've got to make ourselves available to the public, so as a break I just have coke or coffee on the move," he says.

But for others, the lack of breaks does seem to be more of an issue. C+D found that some independent contractors would like to take a break but cannot justify them in the current financial climate. Karen O'Brien, who owns five pharmacies in south Devon, said she could not afford to turn patients away or inconvenience them by not having pharmacists available at all times. "The general public do not accept the fact that a pharmacist is on lunch," she says.

And this pressure stretches beyond pharmacy owners. Sixty per cent of employed pharmacists and 73 per cent of locums told the PDA they had worked through the day without a break "because they either had to or were expected to do so". As Ravi Patel, a C+D award winner and locum says, one patient who was told he was taking a lunch break responded that the pharmacist had "had a lunch break yesterday".

It is clear that being prevented from taking a break when you would like one does little to improve morale, but can it actually threaten your health or abilities at work?

The government's Health and Safety Executive certainly thinks so, as it identifies missing breaks as a possible contributing factor to workplace stress.

The consequences of this stress are hard to accurately assess. But Noel Wardle, of law firm Charles Russell, says while there is no evidence directly linking a lack of breaks to dispensing errors, pharmacists have blamed it in some cases. RPSGB president Steve Churton agrees that being unable to take a break "may sometimes adversely affect... the service that [pharmacists] offer to patients". And of the PDA respondents who had worked throughout the day without a break, over 68 per cent of employees and 71 per cent of locums felt they had at some time put their patients at risk.

Psychologists also agree that missing breaks and the consequent increase in stress can lead to mistakes. Dr Funké Baffour, managing director of Ace Psychology, says, without a break, people may end up producing quantity but not necessarily quality of work. And Dr Frank Bond, a professor of psychology at Goldsmiths University, agrees: "We're human beings and we get tired... we require breaks in anything we do."

Dr Bond says while some people might not suffer from not having breaks, others will and there must be an option for people to take breaks when they need them. And this seems to be the crux of the matter. While it might be fine for some pharmacists to work through the day without a break, that must be a personal choice.

Although it seems clear that being forced to skip that coffee break is not a good way to boost efficiency, and might even have a negative impact on the business or patients, for many pharmacists taking such breaks remains a dream given the constant pressures of the dispensary. The RPSGB says rest breaks are to be a key topic in its upcoming summit with industry leaders on workplace pressures. So the sector must hope that the great and good can come up with some practical, and enforceable solutions to cut the pressure and allow them the option to choose a break when they need one.

Pharmacy leaders on breaks

John Evans, superintendent pharmacist at Asda, says he always takes breaks from work. The first is for breakfast at 7.30am, where "the big discussion is always the consistency of the porridge". And at lunchtime Mr Evans always goes for a walk outside. "It's so easy not to," he says, "but I think it's important to take breaks."

Sue Sharpe, PSNC chief executive, says she rarely manages a full lunch break but sometimes has "a quick walk to the baked potato man". This can be a good break, even if she then eats at her desk, Ms Sharpe adds. "A mental break can be very refreshing, even if it is just for a short time."

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Please note; from January 2009 Ascensia® MICROLET® lancets will be known as simply MICROLET lancets. You will still be able to fulfil your customer's prescriptions for [illegible] same way, but please advise them to get their prescriptions changed to MICROLET [illegible] The PIP code will remain 280-0043 for a pack of 100, and 280-0050 for a [illegible]

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CDMG 01/09

Xrayser

What's your view? haveyoursay@cmpmedica.com

A pharmacist by any other name...

When is a pharmacist not a pharmacist? When he is not registered with the GPhC, of course.

For those pharmacists experiencing "consultation fatigue" (C+D, March 7, p6), the RPSGB's Council has recommended that only those registered with the GPhC should be able to call themselves pharmacists. This incredible suggestion is contained in its response to the consultation on the draft Pharmacy Order.

Our new representative body seems to have shot itself in the foot with this bizarre faux pas, because it won't get many members if it doesn't represent their views. Most members couldn't care less about the intricacies of the Pharmacy Order, but they all want to be proud members of a profession.

I became a pharmacist on completion of my pre-reg year and I expect to remain one until I die. I expect all my colleagues working outside of patient-facing roles, those working outside of pharmacy, the retired and the unemployed to be able to call themselves pharmacists. Doctors, military officers and every other professional I can think of retain this right – why make pharmacy a special case?

This is not about patient safety, it can only be about protectionism by practising community pharmacists. There can be no instance where a patient has suffered, or even experienced traumatic confusion, over a retired GP still calling himself 'doctor'. If the 'doctor' is retired, or is not in medical practice at the time, he is in no position to administer anything other than advice. And no wars have been started because someone suggested to a retired colonel that he invades France.

The simple solution would have been to call those registered with the GPhC 'registered pharmacists'. Everyone else who completed a pharmacy degree and preregistration year could be a 'pharmacist', with some 'practising' and others 'non-practising'. Where's the problem?

> "One can purchase a range of titles from the internet, but it doesn't guarantee a qualification or rich heritage"

Our new professional body was supposed to unite all sectors, but post nominals become meaningless if you can't call yourself a pharmacist. Perhaps the name of this new body should not contain any suggestion it is anything to do with pharmacists. How about 'the Assortment of People with Pharmacy Degrees'? An already divided profession is about to be further sub-divided into 'registered', 'retired' or 'former', 'responsible' and so on. I suggest adding 'fed-up' and 'disenchanted' to this list.

Some might argue that coughing up a few quid to join the GPhC isn't too onerous if you really want to be called a pharmacist. But that cheapens the title, rather than making it exclusive. One can purchase a range of titles from the internet these days, but it doesn't guarantee a qualification or rich heritage. And why on earth would anyone want to join a 'non-practising' register at the GPhC?

Just at the time we need unity and a strong identity we are losing both, and it does not augur well for the future of the profession.

Pharmacist in the House

Sandra Gidley

Sorry shouldn't be the hardest word

I have often said that my workload would be halved if people, especially those in authority, were more prepared to say 'sorry'. It appears that the chief medical officer feels the same way. In his recent Scrubbing Up column he espoused the view that the NHS had to say sorry more often and had to mean it. He's right!

So, what are the barriers to saying sorry? I once addressed a conference attended by people in the public and private sector who had been singled out for leadership training. I expressed the view that politicians should also learn to say sorry and occasionally admit that they had been wrong. A senior Whitehall Mandarin reacted with horror to this outrageous idea and told the audience that I was suggesting the impossible and any admission of 'wrong' would be the end of a ministerial career.

In the workplace I always found that a quick, and sincere, apology followed by appropriate action was nearly always well received. Unfortunately, many people are reluctant to apologise because they are afraid that, if things get nasty, they will find themselves without insurance cover.

There are other barriers too. Some people do not like to admit that they are human and others simply find it a very difficult thing to do, particularly if a patient is distressed. Unless pharmacy courses have changed significantly, I suspect that this sort of human interaction is not taught.

> "There is one person, above all others, who really should apologise to the profession"

But I also started pondering on whether any apologies were necessary in the world of pharmacy. There are many who believe that the Royal Pharmaceutical Society has not done a good job at representation over the years. So it is interesting to note that the current president Steve Churton has effectively apologised for this problem. He may not have used the 's' word, but his words are sincere and he is taking action to address the problem.

There is one person, above all others, who really should apologise to the profession. Dawn Primarolo, as pharmacy minister, was apparently unaware that category M was causing financial heartache for a large number of pharmacists. She could have been remembered as the minister behind the new white paper, but she will now go down in history as the minister who turned disconnection from the profession into an art form. It's not too late to turn things around. She could always say sorry.

Sandra Gidley, Lib Dem MP and shadow health spokesperson

In moderately active ulcerative colitis:

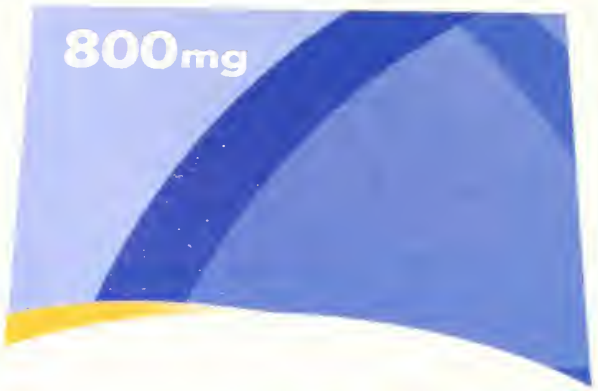
Asacol

goes from

Strength

to

Strength



Asacol® 800mg MR tablets (MESALAZINE)

Asacol 800mg MR tablets, licensed up to 4.8g/day[1]

Each modified release tablet contains 800 mg mesalazine

℞ Asacol 800

by brand name AND tablet strength

Asacol® 800mg MR Tablets Abbreviated Prescribing Information
Presentation: Asacol 800mg MR Tablets, PL 00364/0083, each modified release tablet contains 800mg mesalazine (5-aminosalicylic acid). Product is supplied in plastic (HDPE) bottles containing 180 tablets [illegible]. **Indications:** Ulcerative colitis: Treatment of mild to moderate acute exacerbations. For the maintenance of remission. Crohn's ileo-colitis: Maintenance of remission. **Dosage and administration:** Adults: Mild acute exacerbations: 5 tablets a day in divided doses. Moderate acute exacerbations: 6 tablets a day in divided doses. Maintenance of remission of ulcerative colitis and Crohn's ileo-colitis: Up to 3 tablets a day, in divided doses. **Elderly:** The [illegible] dosage may be used unless renal function is impaired. **Children:** Not recommended. **Contra-indications:** A history of sensitivity to salicylates or renal sensitivity to sulfasalazine. Confirmed severe renal impairment (GFR less than 20 ml/min). Hypersensitivity to any of the ingredients. Severe hepatic impairment. Gastric or duodenal ulcer. haemorrhagic tendency. **Precautions:** Use in the elderly should be cautious and subject to patients having a normal renal function. Discontinue treatment immediately if acute symptoms of intolerance occur including vomiting abdominal pain or rash. Patients with the rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine because it contains lactose monohydrate. Standard haematological indices (including the white cell count) should be monitored repeatedly in patients taking azathioprine, especially at the beginning of such combination therapy, whether or not mesalazine is prescribed. Asacol should be used in extreme caution in patients with confirmed moderate renal impairment. Renal function should be monitored (with serum creatinine levels measured) prior to the start of treatment, and periodically during treatment, taking into account individual history & risk factors. Medication should be discontinued if renal function deteriorates. If dehydration develops, normal fluid & electrolyte balance should be restored as soon as possible. Serious blood dyscrasias (some with fatal outcome) have been very rarely reported with mesalazine. Haematological investigations including a complete blood count may be performed prior to therapy initiation and immediately if the patient develops unexplained bleeding, bruising, purpura, anaemia, fever or sore throat. Stop treatment if suspicion or evidence of blood dyscrasia. Lactulose or similar preparations which lower stool pH should not be concomitantly administered. Concurrent use of other known nephrotoxic agents (e.g. NSAIDs & azathioprine may increase risk of renal reactions. Mesalazine should therefore be used with caution during pregnancy and lactation when the potential benefit outweighs the possible hazards in the opinion of the physician. If neonatal [illegible] suspected adverse reactions consideration should be given to discontinuation of breast-feeding or of treatment of the mother. **Undesirable Effects:** Common: nausea, [illegible], arthralgia/myalgia. Rare: reports of leucopenia, neutropenia, agranulocytosis, [illegible], myocarditis & pericarditis, peripheral neuropathy, vertigo, blood [illegible], alopecia, lupus erythematosus-like reactions and rashes including urticaria, [illegible] function and hepatitis, interstitial nephritis and nephrotic syndrome, [illegible] on withdrawal. Renal failure has been reported. [illegible] Drug fever. Very rarely, mesalazine may be associated [illegible] syndrome & erythema multiforme, interstitial [illegible]. Procter & Gamble Pharmaceuticals UK Ltd, [illegible]. Gamble Pharmaceuticals. Refer to Summary of Product Characteristics for full prescribing information. Date of preparation January 2009 AS7891.

Reference:
1. Asacol 800mg MR tablets Summary of Product Characteristics.
Date of Document Preparation February 2009.

Suspected adverse reactions should be reported.
Reporting forms and information can be found at www.yellowcard.gov.uk.
Adverse events should also be reported to
Procter & Gamble Pharmaceuticals UK Ltd on 01784 474900.

Testing comes under scrutiny

I refer to your recent article 'TV show under fire for intolerance tests advice' (C+D, February 21, p8).

I am writing on behalf of Phadia, which manufactures and produces a point of care allergy test, ImmunoCAP Rapid. This is based on detecting IgE antibodies in blood, the accepted diagnostic method for diagnosing allergy. Blood tests for IgE are widely used in the NHS.

The article was misleading in that it mixed intolerance testing with allergy testing. Watchdog investigated an intolerance test, a condition poorly described and understood.

However, allergies can be accurately diagnosed if IgE testing devices are used. Pharmacies are ideal settings for diagnosing and treating allergies, but they need to be aware proper research should be carried out before offering such tests.

Stuart Chisnall, marketing manager, Phadia Ltd

Letters in brief

'World class commissioning' – what a pompous title. Since no other country in the world has adopted the NHS model of healthcare, there is unlikely to be any competition for the title. Maybe it should be called 'Galactic Class', or even more ambitious 'Universal Class', or dare I suggest 'Multiverse Class'?
Uma Patel, Dunns Chemist Cranford

Letters

Email us with your letters including your name, address and contact number to: **haveyoursay@cmpmedica.com**. Or write to the Editor at: **C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE** Letters may be edited for content and length

Where does pharmacy's future lie?

I think we're in so much of a hurry to lose our 'pill counter' image that we are rushing too fast down the clinical route, thinking that it will lead to more kudos and respect. In my opinion I can see far more benefit in a national medicines management programme; funded centrally, to provide tailored medicines management support for older people and those with special requirements, than will be generated by vascular risk assessments.

The trouble, as far as I can see, is the current contract favours the larger pharmacy chains because:
• purchase profit calculations are always based on profits obtained by independent contractors, such as myself. Multiples can secure much greater discounts and purchasing efficiencies than I can.
• discount clawback is a joke, as we are currently supplying some medicines at below cost, because clawback exceeds available discount in some distribution schemes. The current system which is calculated on the number of items dispensed in the month is quite ridiculous: is a branch of a multiple dispensing 4k items/month buying on the same terms as an independent dispensing the same number of items? No, of course not, they are on their own centrally negotiated terms and they are receiving maximum discount while a smaller proportion is removed by clawback.
• increases in MUR quotas and fees have led to a disproportionate increase in funding for multiples over independents as they tend to conduct more MURs – further widening the funding gap.

The 400/year limit for MURs has meant a lot of people are currently being inappropriately given an MUR as pharmacists are under pressure to achieve their targets. I can see vascular risk assessments going the same way; too much pressure to achieve quantity and not enough to achieve quality.

Ultimately this degrades our image as a profession: GPs get fed up with us sending pieces of paper to them saying 'for information – no action required', patients will begin to question why they have to have another MUR when the one last year, while nice, didn't really add much value to their understanding of their medicines.

If we are going to carve ourselves a niche we should stick to our strengths. A national medicines management programme, you know, the kind that every PCT doesn't want to fund, would allow us to provide emergency supplies using the Scottish model, maybe to realign patients' prescriptions so that they run out at the same time, reducing needless work for the surgery, confusion for the patient, providing extra income for us, and a reduction in waste for the DH. Maybe even an answer to the thorny, and as yet unresolved question of monitored dosage systems, which while a pain for us, do actually seem to help patients and carers alike (not that anyone has bothered to fund any proper research). We could dovetail these with MURs and offer a full patient-centred service which would provide tangible help for patients.

Before we leap on vascular risk assessment we should check the small print. Not every pharmacy would be commissioned (further widening funding inequalities), and it wouldn't be a pharmacy-only service as it is likely other providers (GPs?) could bid for a contract, which could lead to a further leaching of funds from our global sum (unless public health money was actually thrown at the service).

As I'm self employed and my income is directly dependent on the performance of my pharmacy, of course I'll be pushing MURs and VRAs when they come. I just wish that I could use some of the spare money to fund the things that my patients actually want. Give every pharmacy an 'Advanced Service Budget' and let us tailor our services to our communities, and not the top down central approach of the contract so far.

Mike Hewitson, Beaminster Pharmacy, Dorset

Get real and come up with a new pharmacy funding model

The problems regarding category M pricing for generics rumbles on, and will continue to do so, until somebody puts some reality into the way pharmacists are reimbursed for generics.

I was a proprietor community pharmacist until a few years ago, and one of the reasons for selling up was the ludicrous way we were being reimbursed for generics, and the very high prices we were receiving. It was obvious there would be large price reductions [illegible] and my profitability [illegible] affected. Not [illegible] with such [illegible] I decided to withdraw [illegible] while I could.

Despite the price reductions in many Drug Tariff prices, community pharmacists are still vastly over paid for generics and the majority of reimbursement prices are far more than pharmacists actually pay for these drugs.

Just glancing at page 1 of the Community Pharmacy Scotland booklet giving Drug Tariff Part 7 prices, I see pharmacists are being reimbursed for 28 dispersible aspirin 75mg tabs at 82p. Customers only pay £1 for 100 tablets over the counter, and you can get them from the wholesaler at 18p for 28 tablets! There are other anomalies where branded products are cheaper than the prices appearing in Part 7 of the Drug Tariff. For example, salbutamol CFC free MDI is in the DT at £2.88, whereas a Ventolin Evohaler only costs £1.50

Now, I am NOT saying that community pharmacists are overpaid for the service they provide, but that the way of paying them is plain stupid, as part of their income comes from very inflated prices for generic medicines.

If generic prices were matched to prices quoted on the main wholesaler order files (which still leaves scope for pharmacists to buy more competitively), and if those brands that are cheaper than generics are used in the Tariff, at least pharmacists would know where they stood. Then the shortfall in their income could be met by increasing professional fees, and everybody would be operating from a much more certain position. This would also allow for more realistic prescribing statistics when analysing GP prescribing costs.

Until somebody grasps the nettle of the way in which pharmacists are reimbursed for generic medicines, the problems that pharmacists have experienced due to the category M debacle will not go away and there will be the appearance that pharmacists are being grossly overpaid.

Malcolm Gardiner MRPharmS Kyle, Ross-shire

New Ibuleve Speed Relief Gel is available from:
AAH, Enterprise, Phoenix, Sigma, Colorama, Lexon, Mawdsley Brooks, Melchem, K Waterhouse and GD Cooper

IBULEVE Trademark and Product Licence held by Diomed Developments Ltd, Hitchin, Herts SG4 7DR UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watfo[illegible] and Maximum Strength. For the relief of backache, rheumatic and muscular pain, sprains and strains. Also for pain relief in non-serious arthritic conditions. **Ibuleve Speed Relief Ge[illegible]** [illegible]ar aches, pains or swellings, such as strains, sprains and sports injuries. **Directions (Ibuleve Gel):** Lightly apply a thin layer of the gel over the affected area. Massage gently unti[illegible] Repeat as required up to three times daily. **Directions (Ibuleve Maximum Strength Gel):** Lightly apply 2 to 5 cm of gel (50 to 125 mg ibuprofen) to the affected area. Massage gently until absorbed. [illegible] Repeat as required up to three times daily. **Directions (Ibuleve Speed Relief Gel):** Lightly apply 4-10cm of gel over the affected area. Massage gently until absorbed. Wash hands after use. Repeat as required up to three times daily, at least 4 hours apart. **Contraindications:** Not to be used if allergic to any of the ingredients, or in cases of hypersensitivity to aspirin, ibuprofen or related painkillers, especially where associated with [illegible] asthma, rhinitis or urticaria. Not to be used on broken skin, under occlusive dressings (Ibuleve Speed Relief Gel only) or where there is infection or other skin disease. Not to be used during pregnancy or lactation. **Precautions:** Not recommended for children under 12 years without medical advice. If symptoms worsen or persist, consult a doctor or pharmacist. Patients with asthma, an active peptic ulcer or a history of kidney problems should consult their doctor before use, as should patients already taking aspirin or other painkillers. Interaction with blood pressure lowering drugs may occur, but is very unlikely. Keep away from the eyes, nose and mouth. Keep all medicines out of the reach of children. For external use only. **Side-effects:** In normal use, side-effects are very rare, but may occasionally include hypersensitivity reactions, and in susceptible individuals renal and/or gastrointestinal side effects. **Legal category:** P Ibuleve Gel and Maximum Strength Gel; GSL Ibuleve Speed Relief Gel. **Packs:** Ibuleve Gel (PL 0173/0060) - 30g, RSP £3.89 (£3.31 exc. VAT) and 50g, RSP £5.39 (£4.59 exc. VAT), Ibuleve Maximum Strength Gel (PL 0173/0176) – 30 g, RSP £4.95 (£4.21 exc VAT) and 50 g, RSP £6.95 (£5.91 exc. VAT), Ibuleve Speed Relief Gel (PL 0173/0060) – 40g, RSP £5.60 (£4.77 exc. VAT) **Revision date:** July 2003

C+D Clinical

Cancer treatment: the theory

This article describes how cancer cells are produced and how they are targeted by treatments

60-second summary

How does drug treatment exploit the differences between cancer cells and normal cells?

Cancer cells are more sensitive to interference with cell division so a greater proportion are killed by cytotoxic agents than normal cells. Some cancers are sensitive to natural hormones or growth factors, so blocking these with anti-androgens or anti-estrogens can arrest cell growth.

By targeting earlier stages in cell division, before DNA replication, the new biological agents achieve more specificity and substantially reduce side effects. Immunotherapy uses natural immune processes to target neoplastic cells as 'foreign', and some natural immunological cytokines are already in use.

Russell Greene MRPharmS

Cancer represents a failure to control cell division. In the adult body most cells that perform a specific function (eg muscle cells, gland cells) are unable to divide. However, each tissue or organ has a reservoir of stem cells. These are non-functional but can be stimulated to divide when the need arises, such as following injury. They then form functional daughter cells specific to that tissue, a process known as differentiation. For example, if a part of the liver is lost through disease or organ donation, it can regenerate.

Stem cells can also divide to replace their own numbers, and are thus effectively immortal, but once they differentiate they can divide no longer. After regeneration is completed further division is inhibited and stem cells go into a resting phase until needed again.

Other tissues are constantly regenerating as part of normal wear and cell loss, for example blood cells (from bone marrow stem cells), the skin and the gut lining.

In cancer the controls that usually stimulate or inhibit cell division malfunction. One rogue cell mutates, reverts to a stem cell-like state, loses its original function and divides repeatedly. The daughter cells are then termed neoplastic and each division produces two new neoplastic cells.

Individual cells do not always divide rapidly, as is often supposed, but the proportion of dividing cells within the tissue is far greater than normal and drives the growth of the whole tumour.

Research into the processes involved in

CPD

[illegible] (68) can help in [illegible] competencies: **G1a**, [illegible] 68#x7b

Your Continuing Professional Development

CPD

Reflect

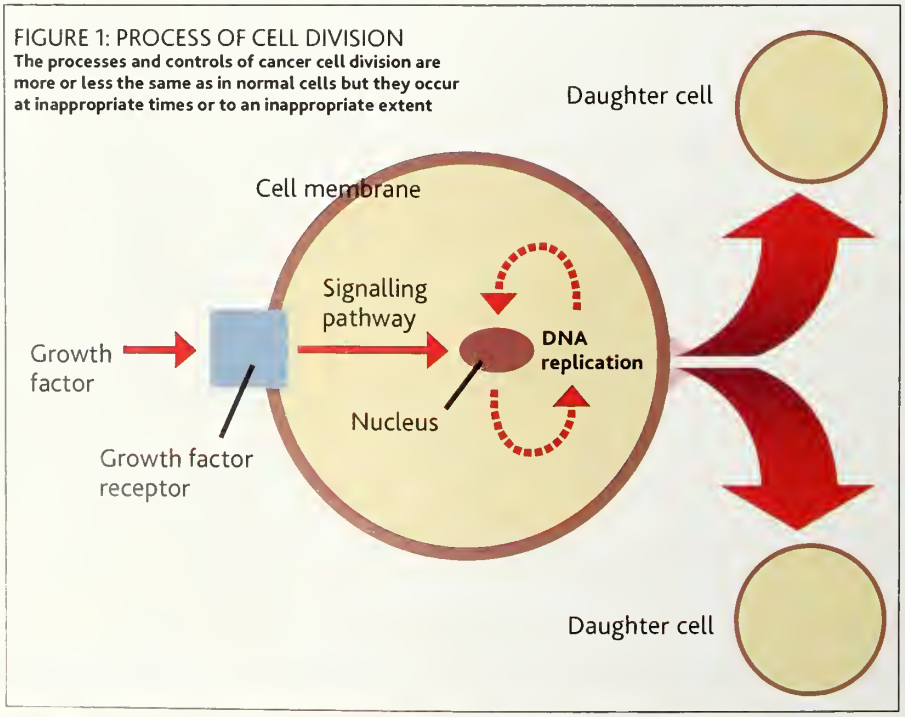
What is the role of cytokines in cell division? How can neoplastic cells be targeted without destroying normal cells? Why do growth factor inhibitors and growth factor receptor blockers have less serious side effects than cytotoxic agents?

Plan

This article describes how tumours are formed and the differences between cancer cell and normal cell division. It explains how these differences are exploited by cancer treatments and includes information on chemotherapy, endocrine therapy, biological agents, gene therapy and immunotherapy.

FIGURE 1: PROCESS OF CELL DIVISION

The processes and controls of cancer cell division are more or less the same as in normal cells but they occur at inappropriate times or to an inappropriate extent



McNeil Products Ltd.
a Johnson & Johnson company

Supporting Pharmacy

March 2009

Dear Pharmacist,

New Advice on use of children's cough and cold medicines

As the manufacturer of an extensive range of over-the-counter (OTC) children's medicines, McNeil Products Ltd (McNeil) is committed to ensuring appropriate use of safe and effective medicines for children. Following new advice from the Medicines and Healthcare products Regulatory Agency (MHRA), McNeil, in common with other leading OTC medicines manufacturers, will update labelling on children's cough and cold medicines to state that they should not be used in children under 6 years. By March 2010, children's cough and cold medicines indicated for ages 6 to 12 will only be available with Pharmacy (P) status.

No requirement to move GSL products from open display

The MHRA has specifically stated that **"Products currently authorised with General Sales List (GSL) legal status may continue to be sold on open shelves and remain available through other retail outlets, such as supermarkets, until the new packaging reflecting Pharmacy (P) legal status becomes available."** McNeil is working with MHRA to ensure newly labelled products are available for a smooth transition no later than March 2010. Your McNeil representative will be able to provide a complete list of affected McNeil medicines.

Single-ingredient pain reliever/fever treatments not impacted

The use of paracetamol (e.g. CALPOL Infant Suspension from 2 months) or ibuprofen (e.g. CALPROFEN from 3 months) remains first line recommended treatment for pain and fever in children. Cough linctus treatments containing glycerol: (e.g. Calcough Tickly and Benylin Children's Tickly Coughs) remain suitable and recommended for use in children from 3 months.

McNeil believes this new guidance from the MHRA reinforces the role of Pharmacy in providing expert advice on children's cough and cold medicines. Please rest assured that we will continue to offer our full support to pharmacists and other health professionals to ensure that children continue to receive the most appropriate treatments for coughs and colds.

Yours faithfully,

D. Mitchell

David Mitchell
Head of Pharmacy, McNeil Products Ltd.

Product Information can be found overleaf

Calpol Infant and Sugar-free Infant Suspension Product Information:
Presentation: Suspension containing 120mg Paracetamol per 5ml **Uses:** Treatment of mild to moderate pain and as an antipyretic. **Dosage:** *Children 1 to under 6 years*: 5 – 10ml; Repeat dose every 4 hours if necessary, up to a maximum of 4 doses in 24 hours. *Children 3 months to under 1 year*: 2.5 – 5ml; Repeat dose every 4 hours if necessary, up to a maximum of 4 doses in 24 hours. *Infants 2-3 months*: Post –vaccination fever at 2 months: 2.5ml, and a second dose, if necessary, after 4-6 hours. The same two doses can be given for the treatment of mild to moderate pain and as an antipyretic in infants weighing over 4kg and not born before 37 weeks. **Contraindications:** Hypersensitivity to paracetamol or other ingredients. **Precautions:** Caution in severe hepatic or renal impairment. Interactions with domperidone, metoclopramide, colestryamine, anticoagulants, alcohol, anticonvulsants and oral contraceptives. **Pregnancy and lactation:** Consult doctor before use. **Side effects:** Rarely hypersensitivity including skin rash and blood dyscrasias. Chronic hepatic necrosis and papillary necrosis have been reported. **RRP (ex-VAT):** 100ml bottle: £2.48; 200ml bottle: £4.16; 12 x 5ml sachets: £2.74; 20 x 5ml sachets (sugar free only): £4.41. **Legal category:** 200ml bottle: P; 100ml bottle: GSL; Sachets: GSL. **PL holder:** McNeil Products Ltd, Maidenhead, Berkshire, SL6 3UG. **PL numbers:** Calpol Infant suspension: 100ml bottle: 15513/0122; 200ml bottle & sachets: 15513/0004. Calpol Sugar-free Infant Suspension: 100ml bottle: 15513/0123; 200ml bottle & sachets: 15513/0006. **Date of preparation:** November 2007

Calprofen 100mg/5ml Ibuprofen Suspension Sachets and Calprofen Product Information. Presentation: Sachets and suspension containing 100mg Ibuprofen per 5ml. **Uses:** Treatment of mild to moderate pain, antipyretic, post-immunisation pyrexia, symptoms of colds and flu and minor sprains or strains. **Dosage:** For Pain and Fever: *Infants 3-6 months, weighing over 5kg:* One 2.5 ml dose may be taken 3 times in 24 hours; *Infants 6-12 months:* 2.5ml three times a day; *Children 1-2 years:* 2.5ml three to four times a day; *Children 3-7 years:* 5ml three to four times a day; *Children 8-12 years:* 10ml three to four times a day. Post-immunisation fever: 2.5ml (50mg) followed by one further 2.5ml (50mg) dose six hours later if necessary. No more than 2 doses in 24 hours. **Contraindications:** Hypersensitivity to ingredients, or to aspirin or other NSAIDs. Peptic ulceration, perforation or GI bleeding. Concomitant use with NSAIDs. Severe hepatic, renal or heart failure. Women in the last trimester of pregnancy. **Precautions:** The elderly; women tying to conceive; history of GI toxicity; concomitant medications increasing the risk of GI toxicity; hepatic or renal dysfunction; bronchial asthma or allergic disease; hypertension or heart failure; SLE and mixed connective tissue disease; chronic inflammatory disease. Not to be used in combination with anticoagulants, corticosteroids, lithium, methotrexate, zidovudine, diuretics and antihypertensives. **Pregnancy and lactation:** Not recommended. **Side effects:** Hypersensitivity, skin reactions, GI disturbances, oedema, hypertension, cardiac failure, exacerbation of asthma and bronchospasm, headache, haematological disorders. Rarely: hepatic dysfunction, peptic ulcer, perforation or gastrointestinal haemorrhage, acute renal failure, papillary necrosis, exacerbation of ulcerative colitis and Crohn's disease and symptoms of aseptic meningitis. **Price (ex-VAT):** Sachets: 12 x 5ml: £3.15; Bottle 200ml: £4.40; 100ml: £2.91. **Legal category:** Sachets: GSL. 200ml bottle: P. 100ml bottle: GSL. **PL holder:** Sachets & 200ml bottle: Pinewood Laboratories Ltd, Clonmel, Ireland; **PL numbers:**. Sachets: 04917/0051, 200ml bottle 04917/0044. **PL holder:** 100ml bottle: McNeil Products Ltd, Maidenhead, Berkshire, SL6 3UG. **PL number:** 15513/0147. **Date of preparation:** July 2008.

CalCough Tickly Product Information:
Presentation: Syrup containing 0.75ml Glycerol Ph Eur per 5ml (15% v/v). **Uses:** Relief of dry tickly coughs. **Dosage:** *Children aged 1 – 5 years*: 10ml 3 to 4 times daily; *children 3 months – 1 year*: 5ml 3 to 4 times daily; *children under 3 months*: not recommended. **Contraindications:** Hypersensitivity to any ingredients. **Precautions:** If symptoms persist for more than 3 days consult your doctor. **Pregnancy and lactation:** Not applicable. **Side effects:** No adverse effects known. **RRP (ex-VAT):** 125ml: £2.91. **Legal category:** GSL. **PL holder:** The Boots Company PLC, 1 Thane Road West, Nottingham NG2 3AA; **PL number:** 00014/0500. **Date of preparation:** September 2007

Benylin Children's Tickly Coughs Product Information:
Presentation: Syrup containing 0.75ml Glycerol per 5ml. (15%v/v) **Uses:** Relief of dry tickly coughs. **Dosage:** Children aged 1 – 5 years: 10ml 3 to 4 times daily; Children 3 months – 1 year: 5ml 3 to 4 times daily; children under 3 months: not recommended. **Contraindications:** Hypersensitivity to ingredients. **Precautions:** If symptoms persist for more than 3 days consult doctor. **Pregnancy and Lactation:** Not applicable. **Side Effects:** None known **RRP (ex-VAT):** 125ml £2.91 **Legal category:** GSL. **PL Holder:** BCM, 1 Thane Road West, Nottingham, NG2 3AA. **PL Number:** 00014/0500. **Date of preparation:** May 2007

initiating, controlling and terminating cell division has revealed a complex interaction of genomic control, chemical signalling pathways and feedback mechanisms. This is what keeps our tissues in equilibrium; loss of this control seems to be the key to cancer. Cells divide in an un-needed and unrestrained fashion, normal controls being unable to terminate the process. The growing colony of neoplastic cells forms a tumour.

How does cancer harm the patient?

A tumour performs no useful function for the body in which it grows. Instead it becomes a parasite, consuming resources such as blood supply, oxygen and nutrients, and taking up ever more space. This bulk causes the initial clinical features: a palpable lump, pain if it presses on local nerves, ischaemia if it compresses a blood vessel, possibly obstruction of the GI tract. But if this were the only problem, treatment might be straightforward, ie it could be cut out.

Unfortunately neoplastic cells have the ability to break away, travel in the blood or lymph to distant body sites and set up secondary colonies or metastases. These are usually numerous and it is impractical to remove them surgically: the tumour is 'inoperable'. Moreover, this process may start when the primary tumour is still young, asymptomatic and undetected. By the time treatment is started it may already be too late.

The frequent cell division may cause another problem, as further mutations increase the likelihood of the development of cells resistant to anticancer drugs, in a process analogous to bacteria acquiring antibiotic resistance.

One further feature militates against successful treatment. For a tumour to be detected, either to the touch, or by causing symptoms, or by scanning, it must be a minimum size of about 100mg. That usually means it already comprises millions of neoplastic cells. Effective treatment requires all of them to be removed or killed, because any remaining cells could start dividing again later, causing a relapse. Thus early detection is crucial, but alas frequently not practicable.

Control of cell division

The processes and controls of cancer cell division are essentially the same as in normal cells but they occur at inappropriate times or to an inappropriate extent. Thus the key to successful treatment is to understand how all cells divide and how to interfere with this process.

The process can be summarised as follows (see Figure 1, p16):

- A special cytokine called a growth factor stimulates a growth factor receptor on the stem cell surface, eg the growth factor erythropoietin causes red blood cell proliferation.
- This stimulus is transmitted via a chain of reactions (the signalling pathway) through the cytoplasm to the nucleus.
- This signal causes the activation, or expression, of a gene that promotes the manufacture of the proteins required for the initiation and control of cell division (an oncogene).
- During cell division, new protein, RNA and DNA are synthesised in a precise sequence culminating in the replication of the cell's chromosomes and eventual splitting into two daughter cells.
- The daughter cells may be two functional cells, a functional cell plus another stem cell, or two stem cells.

Different drugs can interfere at different stages in this process. For better results, several drugs combined at lower doses can give synergistic action and fewer side effects.

Treatment modes

Once a tumour has been detected there are three principal modes of treatment. Surgery is the first choice for a solid tumour that has not metastasised, provided it is accessible and surgery would not be life threatening, mutilating or disfiguring. For locally spread (invasive) lesions radiotherapy can be used. However, most tumours have already metastasised or must be assumed to have started to do so. In this case drug therapy is essential because it can reach remote metastatic sites. Patients often receive several treatment modes. Thus breast cancer may require surgical removal of the primary 'lump', radiation of the surrounding area, including axillary lymph nodes, and follow-up chemotherapy or hormone therapy.

Drug therapy

We have seen that cancer cells use essentially the same growth processes as normal cells; there are no qualitative differences. So any drug interfering with cancer cells could potentially harm cell division in normal tissue, such as the production of new immune cells in the bone marrow. Fortunately there are other, usually quantitative, differences between normal and neoplastic tissue, which can be exploited (See Table 1 online):

- Neoplastic tissues contain increased proportions of dividing cells and are more sensitive to interference in cell division and recover less quickly from interference. Therefore proportionally more are killed by cytotoxic action than are normal cells.
- The growth of some neoplasms is sensitive to natural hormones or growth factors, the action of which can be blocked.
- Intracellular signalling pathways are activated to a different degree in neoplastic cells; these processes can be selectively modified by biological agents such as cytokines.
- Neoplastic cells may have altered immune markers, making them a target for immunological agents.
- Genomic expression may be inappropriate in neoplastic cells, making them targets for gene therapy and agents that interfere with gene expression.

Cytotoxic chemotherapy

Cytotoxic agents are used for solid tumours chiefly as adjuvant therapy, ie following reduction of the main bulk of the tumour surgically or by radiotherapy, to mop up residual local cells and systemic metastases.

Intensive chemotherapy at an early stage in the disease, perhaps in association with radiotherapy, can also be a highly effective treatment of first choice in certain conditions, such as choriocarcinoma, testicular cancer and leukaemia.

However, it is a comparatively blunt instrument because cytotoxic drugs are non-selective. They fatally interfere with cell division at the stage of DNA replication, and so potentially damage any dividing cell. Thus as well as killing cancer cells they kill cells in the bone marrow, hair follicles and gut lining. This can cause the familiar side effects of depressed immunity and blood clotting, anaemia, hair loss and gastrointestinal mucositis with nausea, vomiting and diarrhoea.

Cytotoxic drugs are usually given as a combination of agents in maximum tolerable doses as a course of several short intensive pulses. A recovery period of two to four weeks between each pulse permits regeneration of the bone marrow. The tumour cells recover less rapidly and their number is thus progressively reduced.

Endocrine therapy

Tumours in hormone dependent tissues, particularly genital tumours, may be inhibited if their normal endocrine growth factors (eg estrogen or androgen) are blocked or antagonised. This has the advantage of low systemic toxicity. However, it is cytostatic rather than cytotoxic: it can only arrest the growth of tumour cells or minimise metastasis, not kill them. Therefore it is mostly used prophylactically following tumour minimisation by other modes. In this role it can substantially prolong remissions, eg the anti-estrogen tamoxifen in breast cancer. The side effects once again reflect action on other sensitive but non-neoplastic tissue, eg anti-androgens for prostate cancer causing feminising effects.

'Biological' agents

By targeting earlier stages in cell division, before DNA replication (see Figure 1, p16), these new agents achieve more specificity because these processes are

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PRODUCT INFORMATION. Product Summary. Trade Name of the Medicinal Product: Colgate Sensitive Fresh Stripe. **Indication:** Prevention and treatment of teeth sensitivity and caries. **Contraindications.** There are no known contraindications. Do not use in patients who are known to be sensitive to any of the ingredients. **Special Warnings and Precautions for Use.** There are no special warnings and precautions. The product is used in the same way as a regular toothpaste. Children under 7 use a pea-sized amount for supervised brushing to minimise swallowing. If using fluoride supplements consult your dentist. **Interactions with Other Medicaments and Other Forms of Interaction.** There are no known interactions with other drugs. It is important to note that as for any fluoride containing toothpaste, in children under systemic fluoride therapy it is important to evaluate the total exposure to fluoride (fluorosis). **Undesirable Effects.** None de[illegible] **Legal Class:** GSL **Product Licence Number.** PL 00049/0031 **Product Licence Holder.** Colgate Palmolive [illegible] Ltd Guildford Business Park, Middleton Road, Guildford, Surrey GU2 8JZ. **Recommended Retail Price.** £2.29 (75ml tube) **Date of (Partial) Revision of the Text.** 17 March 2003

PRINCIPLES OF CANCER THEORY

Principle	Rationale
Treat early – when tumour load smallest	Small number of cells to kill Minimise resistance Least chance of metastasis
Use drugs with established activity	
Use effective combinations	Synergistic – reduced toxicity and resistance
Use maximum tolerated doses	Exploit differential sensitivity (tumour/bone marrow) Reduce resistance
Use short pulses	Minimise marrow damage
Allow time for normal (marrow) cells to recover	Exploit differential recovery
Repeat treatment as often as necessary or tolerable	Proportional kill effect
Monitor blood counts closely	Minimise bone marrow toxicity
Use appropriate strategies to minimise toxicity	Eg antinauseant treatments

disproportionally activated or upregulated in tumour cells. This has resulted in a substantial reduction in serious side effects, especially bone marrow depression.

Growth factor inhibitors (eg bevacizumab for colorectal cancer), growth factor receptor blockers (eg trastuzumab for breast cancer), signalling pathway inhibitors (eg imatinib for chronic myeloid leukaemia) and cytokines have produced far better, safer cancer treatments. Research in this area is proving highly productive.

Immunotherapy and gene therapy

Because the immune system can recognise neoplastic cells as foreign (immunosurveillance), the aim is to identify or enhance natural immune processes that can target them (see C+D, Pharmacy Update, January 31 and February 7). Some natural immunological cytokines (lymphokines) are already in use. Interferon is used successfully in Aids-related Kaposi's sarcoma and some lymphomas. Interleukin-2 (aldesleukin, IL-2) has been particularly successful in malignant melanoma and renal cell carcinoma.

The aim of gene therapy would be to change or replace the genes responsible for the neoplastic process. Most treatments here are still experimental. For example, neoplastic cells may have escaped immunosurveillance because a genetic mutation has prevented them from expressing histocompatibility (HLA) antigens. Thus if the mutation could be rectified the tumour might be eliminated by the patient's immune system.

Russell Greene PhD, MRPharmS, is senior lecturer in clinical pharmacy, Department of Pharmacy, School of Health and Biomedical Sciences, King's College London.

Table 1 and a further reading list are online at www.chemistanddruggist.co.uk/update

Your Continuing Professional Development

CPD

Act

- Read more about the types of genes involved in cell division and how they can lead to cancer on the Cancer Research UK website http://tinyurl.com/d3j9ma
- Learn more about cancer treatments by reading the information on chemotherapy, immunotherapy and hormone and gene therapy from Cancer Research UK at http://tinyurl.com/asu5v4. Think how you could explain these treatments to a patient or carer.
- Update your knowledge of the side effects of cancer treatments from the Macmillan website at http://tinyurl.com/cpngwx, which also includes hints on coping with them. Print this out if you think it may be useful when counselling patients.
- Revise your knowledge of the drugs used in cancer treatment by reading Section 8 Malignant disease and Immunosuppression in the BNF.
- For further learning, the CPPE will have an open learning programme. Understanding cancer in pharmacy practice will be available later this year at www.cppe.ac.uk or on 0161 778 4024

Evaluate

- Do you feel more confident in your knowledge of how cancers occur? Are you familiar with the different treatments, how they work and which types of cancer they are used for? Could you explain this to a patient and offer advice about the side effects?

5 MINUTE TEST

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Use your PIN to complete the assessment online or phone through your answers. Your test score will be recorded. If you successfully complete the 5 Minute Test online, you will also be able to download an RPSGB-approved CPD certificate. It's that simple.

Registering for Update 2009 costs £32.50 (inc VAT) and can be done easily at **www.chemistanddruggist.co.uk/update** or by calling 01732 377269.

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Get an RPSGB-approved CPD certificate for your portfolio when you successfully complete the 5 Minute Test online

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Each month all those who complete the CPD for at least one module without making a single mistake will be entered into a £50 prize draw. And those who achieve a year's-worth of correct answers will be entered into a £400 prize draw.

The Update February winner is HK Patel of Bishops Pharmacy, 7 Lyttelton Road, London N2 0DW

YOUR GUIDE TO...

Vascular screening

Next month the national vascular risk assessment programme officially begins. But what does that actually mean for pharmacy? Zoe Smeaton finds out what you need to know

Blood pressure monitoring, cholesterol checks and calculating BMI are just a few of the components of the new vascular screening service

Vascular risk assessments can't be ignored. If you're planning to push ahead with clinical services to boost your service to patients and your business, the appeal is obvious. But PSNC also warns that the assessments are a strategically important service that pharmacy needs to use to prove it is willing to engage and can deliver high quality care.

And given the support the assessments have from the very highest levels – in January last year Prime Minister Gordon Brown promised that people would "soon" be able to access free check-ups to monitor for heart disease, stroke, diabetes and kidney disease – their importance cannot be underestimated.

So what actually is a vascular risk assessment?

As the name suggests, an assessment is all about estimating a person's risk of developing chronic conditions affecting the vascular system, such as coronary heart disease, stroke and diabetes. These conditions are linked by a number of common risk factors including obesity, smoking, high blood pressure and impaired glucose regulation, all of which pharmacists and other healthcare professionals can test for.

Although the actual service protocol will vary from PCT to PCT, a typical assessment might involve taking a patient history, including details about whether they smoke, exercise, eat healthily etc; measuring their height and weight to calculate a BMI; taking a waist circumference and blood pressure reading; and then carrying out a cholesterol and blood glucose check using a pinprick blood test.

After the tests have been carried out, a 'risk' is calculated using computer software. Depending on the result the patient can be offered advice to help improve their lifestyle, or referred to other services or GPs. Pharmacists can offer the lifestyle guidance, for example advising on healthy eating and exercise, as well as providing some of the follow up services such as smoking cessation or weight management. For those at highest risk, GPs can offer prescription medicines if necessary.

In pharmacy vascular risk assessment schemes launched in Islington and Manchester, risk assessment data is forwarded or faxed on to GP surgeries, which are aware of the scheme and can follow up with patients when necessary. It is hoped that eventually results will be transferred electronically using a template transfer form to be provided by PSNC, making the process even smoother.

So which pharmacies can get involved?

All pharmacies across England should be able to get involved in vascular risk assessments. Pharmacist Neil Patel, who has been involved in the risk assessment scheme in Islington, says he sees no reason why any pharmacist, after they receive the appropriate training, would not be

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Weight loss is a vital part of cardiovascular risk management and weight loss with Xenical can have a significant impact upon key risk factors.[1-5] When you help change their weight, you help change their future.

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Roche **PRESCRIBING INFORMATION. XENICAL (orlistat). Indications:** XENICAL is indicated in conjunction with a mildly hypocaloric diet for the treatment of obese patients with a BMI ≥30 kg/m², or BMI ≥28 kg/m² with associated risk factors. Treatment should be discontinued after 12 weeks if patients have been unable to lose ≥5% of their body weight. **Dosage and administration:** One capsule immediately before, during or up to one hour after meals (only 30% of calorie intake from fat). **Contra-indications:** Chronic malabsorption syndrome, cholestasis, breast-feeding, known hypersensitivity to any component of the product. **Precautions:** Monitor anti-diabetic drug treatment. Co-administration of orlistat with ciclosporin is not recommended. Treatment may potentially impair the absorption of fat-soluble vitamins (A, D, E, and K), patients should be advised to have a diet rich in fruit and vegetables. The possibility of experiencing gastrointestinal events may increase when orlistat is taken with a diet high in fat. Caution should be exercised when prescribing to pregnant women. Studies have shown no interaction between orlistat and oral contraceptives, however an additional contraceptive method is recommended to prevent possible failure of oral contraception that could occur in case of severe diarrhoea. Rare cases of rectal bleeding, generally of mild intensity have been reported and prescribers should investigate further if symptoms are severe or persistent. **Drug interactions:** A decrease in ciclosporin levels has been observed in an interaction study. Co-administration with acarbose should be avoided. INR values should be monitored if patient is on warfarin or other anticoagulants. Reinforcement of clinical and ECG monitoring is warranted if patient is on amiodarone. **Side-effects:** Please consult the Summary of Product Characteristics for full details of adverse events. **Common:** Influenza, anxiety, headache, respiratory infection, urinary tract infection, menstrual irregularity, fatigue, [illegible] such as oily spotting, abdominal pain, flatulence. Treatment adverse events hypoglycaemia and abdominal events decreased with prolonged cases of increases in liver transaminases and also cases of hepatitis. Very rare diverticulitis and cholelithiasis angioedema, bronchospasm and POM. **Presentation and Basic N**[illegible] (84 capsules) £33.58. **Marketing Authorisation Number:** EU/1/98/071/003 (84 capsule blister pack). **Marketing Authorisation Holder:** Roche Registration Limited, 6 Falcon Way, Shire Park, Welwyn Garden City, AL7 1TW, UK. Further information is available on request. Xenical is a registered trade mark. **Date of preparation:** June 2007.

References: 1. Hollander PA et al. Diabetes Care 1998; 21: 1288-1294. **2.** Hanefeld M and Sachse G. Diabetes Obes Metab 2002; 4: 415-423. **3.** Sharma AM and Golay A. J Hypertens 2002; 20: 1873-1878. **4.** Broom I et al. Br J Cardiol 2002; 9: 460-468. **5.** Torgerson JS et al. Diabetes Care 2004; 27: 155-161

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J97920557 August 2008.

capable of doing these assessments. Practising first on staff can help, and he says his confidence has grown as he has done more and more of the tests.

Further guidance will be made available from LPCs and PCTs when any service is commissioned, but all pharmacies will require a consultation room in which to carry out the checks. Financial investment in equipment may also be required, although PCTs may be persuaded to offer some support for this.

As well as the necessary machines and equipment to carry out the physical tests, pharmacies will need IT support to run the risk calculations and store any data required. SOPs will also have to be put in place to cover the checks, and issues such as clinical waste disposal and point of care testing governance should be kept in mind.

And as with many services, pharmacists will need to gain relevant training and consider how to delegate certain tasks to appropriately trained staff. Pharmacists involved in pilot schemes stress that this delegation, such as asking support staff to fill out the patient questionnaire, does ease the pressure. You can see a video of Neil Patel carrying out a vascular risk assessment at: www.chemistanddruggist.co.uk

"Investment in equipment may be required"

And what happens in April?

It all begins in April, but all that really means is April 1 is the date on which PCTs must begin introducing the service. They must commission the service out to primary care providers, and "show some evidence of participation" with the programme in 2009. The trusts will start to receive their funding for it in the 2009-10 financial year, but the DH suggests implementation could be phased over as many as five years, so without a push from providers things might not get moving quickly.

So what can I do next?

At the moment, pilot schemes have been rolled out in a number of locations, including Islington where the pilot is now complete, and Manchester, and LPCs from around the country are receiving training from PSNC. The PSNC workshops cover a range of topics, such as how to bid for services, pricing, quality assurance and how to market services, highlighting strategies used by pilot schemes.

Armed with this background there is clearly still a lot of work for LPCs thinking about how to approach their PCTs. LPCs may be bidding for a service developed by the PCT, or they might have to be more proactive and actually make a service proposal to the PCT themselves. This could be made easier by the PSNC service specification, which is expected shortly.

For individual contractors wanting to get involved, a first step would be to approach the LPC to find out how the committee is planning to move the agenda forwards, as well as taking steps to ensure their own pharmacy is ready, and possibly talking to other providers to gain their support for a pharmacy-based scheme.

Any top tips?

The basic tactics for securing a vascular risk assessment scheme are the same for all enhanced services – pharmacy needs to put a convincing case to the PCT, demonstrating it can provide value for money, carry out high quality services and meet local health needs.

The challenges faced by the profession in getting any service commissioned will apply, as C+D warned after the PSNC conference in November 2008 (C+D, November 22, 2008, p12). With vascular risk assessments, there are particular issues though. PSNC warns DH eyes are likely to be on the profession to see if it can deliver as it has promised. The committee also urges contractors to respond with enthusiasm and professionalism to ensure they get it right.

Another potential pitfall arises because government funding has been set aside for the service and, because it is open to all primary healthcare providers, there is likely to be competition to provide the service, for example from GPs. To avoid being left behind it is vital pharmacy acts fast, ensuring conversations with PCTs begin quickly and do not stall. Pilots offer a great way to test out a service, offering a chance to both make improvements as things move forwards and demonstrate the willingness and capabilities of pharmacy.

Aneet Kapoor, a pharmacist and LPC member involved in the Manchester scheme, agrees that while any service needs to be attractive for pharmacy, it is not worth getting too caught up in the finer details in the early stages of a pilot. "We wanted to get the service out as quickly as possible," he says. "It doesn't have to be the perfect service at the start, it can be reviewed and issues dealt with once it's out there."

See Manchester LPC's top tips at: www.chemistanddruggist.co.uk

GPs and PCTs the vital stakeholders

Aneet Kapoor, of Manchester LPC, says GPs in the area have been fairly supportive of the scheme. For example, he has been into his local surgery and identified patients from their records who might benefit from the screening and could be targeted with letters promoting the service. Reaching such patients could actually help GPs to meet their targets, and Mr Kapoor adds that selling the service to GPs in this way has helped secure their support.

In some cases GPs may not be so positive, for example David Kent, LPC secretary in Islington, says some doctors expressed concerns about the service. But he adds that by getting on with things quickly and dealing directly with the PCT, pharmacy did not have any problems.

Doctors cannot be ignored completely though as they are vital when it comes to making referrals after the tests. Mr Kapoor suggests keeping them informed by sending an LPC representative to an LMC meeting to explain the benefits of the service and how it can help GPs.

LPC meetings can also be used to gain the support of the PCT, which is the most important step in securing any commissioned service.

Kate Kinsey, director of the public health unit at Manchester PCT, agrees. Ms Kinsey played a key role in securing the Manchester pharmacy service and advises LPCs that gaining the support of even one PCT member, who can champion the profession to colleagues, is a vital first step. "Every PCT will have somebody somewhere who will be looking after the interest of pharmacy," says Ms Kinsey. So, gain their trust and support as well and you'll be well on the way to success.

For videos on how to carry out a vascular risk assessment and Manchester LPC's top tips, see www.chemistanddruggist.co.uk

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Fin McCaul tells Chris Chapman how it feels to lead the C+D Pharmacy Team of the Year 2008

Teaming with talent

Casting his mind back to the black and gold trophy he held in June last year, Fin McCaul has no doubt how he feels. "It was the best award we could have won," he says simply. "It was for everybody, not just one individual."

His thoughts are testimony to the team spirit that carried those at Prestwich Pharmacy in Greater Manchester through nothing short of a revolution in their business to triumph in the Pharmacy Team of the Year category at the 2008 C+D Awards.

The task facing the team was daunting; after three years in a Portakabin, the pharmacy relocated to a new two-storey premises, complete with two dispensaries, two counselling rooms, three treatment rooms and a host of training facilities.

If that gargantuan task didn't raise enough challenges, the premises also included a new IT network and a dispensing robot to master. In short, the team had to adopt a whole new way of working.

And the 35-strong team at Prestwich stepped up to the plate, embracing the new location and the challenges it brought with staggering enthusiasm and commitment.

Looking back, Mr McCaul knows exactly why the team succeeded. "We could never do it without everybody," he enthuses. "There were lots of challenges, but we tried to involve everybody in it and make them understand how important they are in the business."

Mr McCaul says the team bubbled with new ideas, continually suggesting tweaks and improvements and creating a healthy, happy working environment.

The team is always working on various health initiatives, which has led to the pharmacy offering a staggering range of services. These include MURs, a minor ailments scheme, health checks, blood sugar testing, cholesterol testing, weight management services and smoking cessation.

If the array of pharmacy services wasn't enough, Prestwich hosts a gift department, digital mini-lab (complete with portrait studio) and a wholesale services department. The pharmacy has also branched out into [illegible] offering chiropody, [illegible] and massage. Other services [illegible] travel clinic, beauty [illegible]

Fin McCaul, second left, with pharmacy assistant Danielle White (far left), store manager Shirley Redford and McNeil Products head of pharmacy David Mitchell

C+D 08 AWARD WINNER

The pharmacy's atmosphere encourages initiative and creativity beyond the business, too; the team members always turn their thoughts to the local community. They arrange charity events ranging from fancy dress to raffles for a range of worthy causes, including Jeans for Genes Day, Children in Need and Breast Cancer Awareness.

"We do a 24-hour walk for life in June [for Cancer Research UK], and we were having discussions this afternoon about a local carnival... some of the staff were talking about how we could get involved in that," Mr McCaul says. "We keep trying to get involved in the community; it's not easy, but we do keep trying."

The close-knit team has enabled Prestwich to achieve Investors in People accreditation, which reveals how vital it is to have a structured business and ensures staff remain motivated and productive in all areas of the business.

Every member of staff is also involved in the company business plan, giving them all a vision for the future of the business and their particular role.

It's a concept that empowers teams to work toward personalised targets and allows the directors to feel confident they're well positioned to overcome whatever challenges they face in the next decade.

The team at Prestwich Pharmacy hasn't just tackled one area of business; it's overcome the challenges and teething problems of sculpting a true 21st century pharmacy. And the secret, Mr McCaul believes, is that everyone plays their part.

"I couldn't single out any aspect of the shop," he says. "It's everybody working together that makes this so much fun."

Prestwich Pharmacy file

Name: Prestwich Pharmacy

Location: Prestwich, Greater Manchester

Award won: C+D Pharmacy Team of the Year 2008

Award entry: The judges felt the entry "stood out from the crowd" thanks to its demonstration of how crucial leadership and teamwork should be in a modern pharmacy.

The McCaul tells Chris Chapman how it feels to le

Teaming wi

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C·D 08 AWARD WINNER

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to raffles for a range c
including Jeans for Gene

Prestwich Pha

Name: Prestwich Pharr

Location: Prestwich, Gr

Award won: C+D Pharr
2008

Award entry: The judg
out from the crowd" th
demonstration of how
teamwork should be in

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Products in brief

Deficiency addressed

An effervescent supplement to prevent and treat calcium and vitamin D deficiency will be launched by Novartis Consumer Health in April. Sandocal+D 600 Effervescent tablets contain 1,358mg calcium lactate gluconate, 1,050mg calcium carbonate and 4mg colecalciferol.
Price and pip codes: £5.35/60 342-0825; £8.75/100 342-0817
Novartis Consumer Health
Tel: 01403 210211

Kalms' 84-size pack

An 84-tablet blister pack of Kalms Sleep has been launched by LanesHealth, joining the existing 50-tablet bottle. A trade campaign will support the launch.
Price: £4.69; Pip code: 341-6567
LanesHealth; tel: 01452 507458

Wrinkle buster

Stimulskin Plus Divine from Darphin is a new anti-ageing lifting skin cream with botanical extracts that claims to improve firmness, elasticity and appearance.
Price: £117.45/50ml
Darphin; tel: 0870 034 2318

Back in stock

Fersamal syrup (ferrous fumarate, 200ml) is in stock and available to order, says manufacturer Goldshield Pharmaceuticals.
Movianto UK; tel: 01234 248632

Testing is on the move

Omron is introducing two digital automatic blood pressure monitors suitable for use out of the home. The MIT Elite and MIT Elite Plus are upper arm blood pressure monitors with a large LCD display and slim design.

Features include easy one-button operation, memory of 90 measurements with date and time plus an averaging function. The monitors can detect if irregular heartbeats jeopardise the measurement quality and display only valid results. An icon displays irregular heartbeats.

The MIT Elite Plus includes the USB cable and software necessary to run a tracking program, enabling the user to be able to share their blood pressure history with their clinic or doctor. This model also features a display backlight for ease of use during the evening.

Both monitors come with a medium sized cuff (22 to 32cm), soft storage case, a set of batteries and a blood pressure diary. A large cuff (32 to 42cm) is available as an accessory.

Price: Elite £97.82; Elite Plus £117.40
Pip code: Elite 344-8586; Elite Plus 344-8594
Omron Healthcare (UK)
Tel: 01908 258285

Sensodyne Pronamel whitens up

A new whitening toothpaste for people with sensitive teeth has been introduced under the Sensodyne Pronamel brand.

Sensodyne Pronamel Gentle Whitening is designed to help protect against acid erosion while also gently restoring the teeth's natural whiteness.

The product is formulated with the benefits of a regular toothpaste and has a cool mint taste.

It is packaged in the brand's stand-up tube with a white pearlised cap to aid differentiation.

Sensodyne Pronamel will be backed by a major support programme later this year starting with testimonial-style advertising for the new product in the summer.

Price: £4.29/75ml
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Romance gets into the air with Impulse

Unilever UK hopes to re-invigorate the female body spray market with the launch of a new Impulse fragrance and redesigned packaging across the entire Impulse range.

Newest addition to the fragrance range is Impulse Romantic Spark, which is a subtle blend of wild violet notes and white wood scents.

The contemporary new packaging is designed to strengthen the brand's appeal to 17 to 24-year-olds and reinforce the association that Impulse has with romance. It is also intended to stand out on shelf.

The range will be supported by a £3 million marketing programme that includes TV, print and press advertising and an extensive consumer sampling campaign.

Impulse is the brand leading female body spray in the UK (source: IRI value share all outlets 52 w/e 27 Dec 2008).

Price: £2.19
Pack size: 75ml
Pip code: 343-0188
Unilever UK
Tel: 01372 945000

For on TV this week see: www.chemistanddruggist.co.uk/prodnews

Dad can look his best

Just for Men will be supported by a £1 million national TV campaign on air until the beginning of April.

The commercial features a greying father and his two daughters who encourage him to use Just for Men to help him look his best before going out on a date.

This burst of TV advertising is part of a £4 million spend on Just for Men throughout 2009. The brand is targeted at men in the 35 to 45 age group.

Combe International will launch a new hair colour range for men to consumers at the beginning of May. The Touch of Grey range is designed to appeal to older men in the 45 to 55 age group who want to gradually blend away grey hair (see next week's C+D for details).

Product info
Combe International
Tel: 0208 680 2711

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Survival guide PART FOUR

Should I sell up?

CREDIT CRUNCH SURVIVAL GUIDE

Anne Hutchings looks at whether a recession is a good time to sell your pharmacy

I speak to hundreds of potential pharmacy sellers and what comes across over and over again is that choosing when to sell is a very difficult personal decision. A typical comment is: "I am thinking of retiring but not quite sure if I am ready to go yet."

People sell their businesses for a number of reasons that are not just financial, such as retirement, poor health, partner/spouse problems, or because they have simply had enough.

The current economic downturn has added another dimension; pharmacists are concerned about whether the recession will affect their ability to sell and whether it will affect the price they hope to achieve for their business. Hopefully I can give you some guidance in this area.

Five selling facts

1 It is still a seller's market. You may ask how I define this. Well, there are more buyers than sellers. Most pharmacies that come onto the market attract a good level of interest from prospective buyers and, as long as they are correctly priced, the vendor can expect several offers. I should clarify that buyers are looking for good quality pharmacies, ie those without problems, such as doctors moving away or 100-hour contracts opening up nearby. I have noticed recently that buyers are more discerning and will walk away if they find a pharmacy has problems. I would therefore recommend anyone thinking of selling should make sure they are aware of any changes or proposals in their vicinity that could have an adverse affect on their business. If there are any problems, try and find a solution if possible before putting your business on the market.

2 There is a shortage of pharmacy sellers. We have seen fewer pharmacies come onto the market in the last few months. This has resulted in increased competition for the pharmacies that are available.

3 Pharmacy buyers are on the increase. For example, in January 2009, 57 new buyers registered with us compared with 35 in January 2008. We have also noticed an increase in the volume of phone calls from buyers who are anxious to see if there is anything new on the market. From a buyer's perspective prices have come down from the peak of 18 months ago. Prices fell due to category M, which has resulted in reduced pharmacy profits. Prices are around 15 to 25 per cent lower following category M. This is contributing to the ongoing interest of pharmacy buyers who can now acquire pharmacies at more realistic prices. So far, the majority of pharmacists we deal with do not have to sell their business, they will only proceed if the price is right.

Therefore it has not been easy for buyers to pick up a bargain. This could change during the recession as I expect a few pharmacies will have to be sold by vendors who have overstretched themselves.

4 Following the category M fall, pharmacy prices are stable and holding up well in the recession. For most pharmacists, the majority of income is from prescriptions, making pharmacy relatively recession-proof. The banks recognise the strong business model and are therefore providing loans to buyers. However, loans are tending to take longer to be approved, therefore sellers should factor this into the overall timescale for selling.

5 Many pharmacy groups are keen to acquire more pharmacies. They see this as strategically strengthening their position in the marketplace, increasing their buying power and putting them in a better position to use their resources.

What does the future hold?

Other than uncertainty, it is difficult to know. Pharmacy is a good business to be in during a recession so prices should hold up.

Looking further ahead, even when we come out of the recession – whenever that may be – there is no reason to believe pharmacy prices will increase. Prior to the category M issue pharmacy prices were extremely high; one has to question whether they would have been sustainable in the long term regardless of category M.

There is always uncertainty regarding what the government has in store for pharmacy. One thing for certain however is the government will be a bit short of money following all the bail-outs, increased unemployment and reduced tax revenues. You couldn't blame pharmacists who wonder if another category M is around the corner and what would that do to goodwill values? The government has already indicated that tax will be increasing so who knows where this will end? Under the circumstances, holding on to the pharmacy may be a more risky strategy than selling now.

I cannot see anything to indicate pharmacy goodwill values will increase anytime soon. If you are thinking of selling, now is probably as good a time as any. A few pharmacists have told me they wish they had sold a couple of years age; life would be easier with hindsight. However, the people who sold at the peak would have also invested the proceeds of their business sale at the top of the market. Enough said.

> "It has not been easy for buyers to pick up a bargain. This could change during the recession"

What is the alternative to selling if you have had enough of pharmacy? Assuming your business is profitable enough, you could put a locum/manager in and take a back seat, hoping that pharmacy prices improve in the future. If you are optimistic about the future of pharmacy this may be the answer for you.

If you are still unsure about selling, ask yourself the following questions:

- What would you really like to do with your life?
- Does your pharmacy fit in with the lifestyle you want?
- Would you have a more enjoyable life without the pharmacy?
- If you sell your pharmacy, would the money from the sale – after paying off loans and tax – be sufficient to maintain the new lifestyle you wish for?

If your answers are pushing you in the direction of selling your business, you will be well advised to prepare for the sale. In my next article I will be looking at this in some detail.

Anne Hutchings, Hutchings Consultants Pharmacy Brokers
Tel: 01494 722224
www.hutchings-pharmacy-sales.com

Missed any parts of the Credit Crunch Survival Guide? See all the articles at **www.chemistanddruggist.co.uk/creditcrunchsurvivalguide**

Next week in part five of the Credit Crunch Survival Guide:
How to make money from photography

For more real-life scenarios see:
www.chemistanddruggist.co.uk/practicalapproach

A Practical Approach

Knobbly knuckles

David Spencer, pharmacist at the Update Pharmacy, is having a day off. He has just finished a round of golf and is having a drink at the club bar, when someone taps him on the shoulder. He turns to see another club member, who he does not know.

"It's Dave, isn't it?" says the man. "You're a chemist aren't you?"

"Yes, I'm David and I'm a pharmacist," David replies.

"That's good," he says. "I was really looking for a doctor, but there aren't any here today. You're the next best thing."

"What can I do for you?" David says, feeling rather irritated.

The man holds out his hands. "Do you know what this is? I've got knobbly knuckles."

David's interest is aroused by the appearance of the man's hands. Beneath the skin over each knuckle of the fingers of both hands is a white nodule. "Can I touch them?" he asks.

The man agrees and David can feel that they are quite mobile but hard and gristly.

"Do they hurt?" David asks, to which the reply is "No".

"Do you have them anywhere else?"

"I've got something similar on my heel."

"Do you have heart trouble or any other illnesses?"

"That's a funny question, but no," comes the reply.

"Does anyone in your family have a history of heart disease or stroke?"

The man thinks for a moment. "Come to think of it, yes; two of my uncles died from heart attacks before they were 60."

"And how old are you?" asks David.

"I'm 36."

Questions

1. What might these nodules be and what condition might they indicate?
2. What other signs might a pharmacist see?
3. What should David advise?

Can you suggest a scenario for Practical Approach? We're offering a £10 Amazon voucher for those we publish. Email ideas to haveyoursay@cmpmedica.com

Answers

1. Tendon xanthomata – cholesterol ester deposits deep within the tendons. They are characteristic of heterozygous familial hypercholesterolaemia, a dominantly inherited genetic disorder leading to very high serum cholesterol (9-12 mmol/l). Prevalence is about one in 500. Over 50 per cent of affected men die before 60 if untreated, and it is not uncommon for men to have their first myocardial infarction or develop angina in their 30s; 15 per cent of women with familial hypercholesterolaemia die of CHD before age 60. Other common sites for xanthomata are the Achilles tendon and over the tendon connecting the tibia to the patella.

2a) Corneal arcus, a greyish white opacification around the edge of the cornea. It is a particularly sensitive sign of familial hypercholesterolemia in people under 50, but is not diagnostic of hyperlipidemia when observed in older men and women and those of African descent. More than two-thirds of men and women aged over 80 have corneal arcus.

b) Eruptive xanthomas, painless yellowish papules on an erythematous base, presenting as grouped lesions, especially on the elbows, and the chest and buttocks (the latter two would not normally be available for a pharmacist to see).

3. To see a doctor urgently.

This article can help in the following CPD competencies: **G1a, G1c, G1d, G2o.**
See http://tinyurl.com/68ox7b

PRE-REG EXAM Q&A

C+D has launched a new weekly pre-reg exam Q&A series. Every week we will publish a Q&A to help test your knowledge ahead of the pre-reg exam, and show you how the answer is calculated. The first Q&A was published last week but they will usually be published online at **www.chemistanddruggist.co.uk/generationrx**. To get the Q&A emailed to you automatically each week, sign up to C+D's free weekly newsletter at **www.chemistanddruggist.co.uk/register** So, put the kettle on and see if you can beat your tutor in the pre-reg Q&A.

Question 2

A one year old child has been found to be anaemic. The child's mother brings in to your pharmacy a prescription issued by a hospital paediatrician for sodium feredetate elixir, 2.75mg iron/kg daily. Assuming that the child is of average weight for its age, what dosage of the elixir would you supply?

A 1.25 ml daily

B 1.25 ml twice daily

C 2.5ml daily

D 2.5ml twice daily

E 5ml twice daily

This is an open book question (references allowed: BNF 56; MEP 32; Drug Tariff [England and Wales] Feb 2008).

Answer: D

Rationale/Explanation
Reference: BNF. Average weight for age of children can be found on sheets inside the back cover: One year old = 10kg.

Dose of sodium feredetate elixir = 2.75 x 10 = 27.5mg daily. Sodium feredetate elixir contains 27.5mg/5ml, therefore the dosage would be 2.5ml twice daily.

Notes
RPSGB registration exam syllabus sections: 2 – Clinical and pharmaceutical practice. Part I – Clinical practice. b) Action and uses of drugs; Part II – Pharmaceutical aspects of practice. a) Calculation.

For more pre-reg exam questions, remember to logon to www.chemistanddruggist.co.uk/generationrx every Friday.

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Looking for a new job? Got a staff problem? C+D's new weekly careers section is your one-stop guide to making the right decisions

The medicines man

The MHRA might not seem an obvious option for a career, but it's home to one of the UK's most influential pharmacists. Zoe Smeaton reports

Tackling ministerial questions and meeting the demands of the UK's national newspapers are not easy jobs, but throw in responsibility for the licensing of new medicines in the UK and some unpredictable patient queries and you're somewhere near to a day in the life of Dr Siu Ping Lam.

As deputy director of licensing at the MHRA, Dr Lam is one of the more influential pharmacists in the UK. And he is not alone in the department, where he says pharmacists are a common sight.

When a licence application comes in, the drug's initial assessment is carried out by a pharmacist. The assessors look at all the quality aspects of the drug, analysing the chemical data and evidence to see whether the product is suitable and pure. The pharmaceutical assessors must also ensure the dosage is correct and the product stable; and how such factors might translate into shelf life and labelling.

"It's very challenging scientifically... you need to be able to see through complex data to make sure it's reliable and valid," Dr Lam says. And hailing from Chelsea College, University of London, he was well prepared for the challenge as he followed a scientific path in the years following his pharmacy degree. After completing his pre-reg training in a London independent community pharmacy, he gained a PhD in medicinal chemistry, going on to a post-doctoral fellowship. His life at the MHRA (then the MCA) began in 1989, and he hasn't looked back since, working his way up from his first position as a junior pharmaceutical assessor.

Working through the licensing department, Dr Lam has considered everything from homeopathic products, through to parallel imports and medicines devices.

But he says the work is not all science. Pharmacists in the MHRA are now also attending meetings with regulators in other countries and influencing European medicine policies. And the work of the licensing department often hits the headlines, such as in recent stories on a meningitis vaccination and controversy over a medicinal product derived from cannabis. Dr Lam says his first job of the day is to "see if there are any hot topics we need to tackle... the press office might be telling me what has happened or I could be giving ministers advice for parliamentary questions".

And then there are the patients. As the people ensuring the quality, safety and efficacy of medicines, Dr Lam says the licensing team are the medicines "guardians of the public", which is no small responsibility. Dr Lam says his work is not only exciting from an intellectual point of view, dealing with the leading medicinal developments every day, it's also rewarding to feel as though he is making a real difference for patients. "The most valuable thing is that we're in a position to make decisions that will have an impact on public health." The department may also have to answer some safety-related queries from individual patients, such as asking whether colourings in medicines could be a problem for their children.

It is this patient focus which makes working in a community pharmacy such a valuable experience, Dr Lam says. "When you're working in a community pharmacy... you see the type of questions that patients are asking. At the agency we always have that in mind when we're looking at medicines and patient leaflets... knowing what questions patients are likely to ask helps us see what might cause problems," he explains.

So it might not be the first employer you think of if you're working in community pharmacy, but the MHRA is certainly one to consider. The agency is actually the largest employer of pharmacists in one location in the UK – beating even nearby hospitals and the Royal Pharmaceutical Society – and recruits pharmacists into a range of roles. Pharmacists can be seen leading MHRA communications, carrying out inspections, authorising clinical trials and making those all-important decisions on POM to P switches.

And if it's the licensing department you're after Dr Lam says if you feel you have the intellectual capabilities for the job, then go for it. "It's a [illegible] job, and quite different from other positions for pharmacists... it's exciting," he adds.

CAREER TIP of the week

"There is a natural tendency to make your offerings appeal to as wide an audience as possible. Paradoxically, you are often better marketing an offering to a tightly defined niche market. The more precisely your product fits your customers' needs the easier it will be to sell, and the easier your market will be to defend"
From Brilliant manager, by Nic Peeling
www.chemistanddruggist.co.uk/booksforjobhunters

Your QUESTIONS answered

What should I do about late staff arrivals?

Q One of my support staff has started turning up late for work and seems distracted, though she's always been reliable in the past. How should I approach her about the downturn in her performance?

Rowlands Pharmacy human resources manager Sandra Roberts (pictured) responds:

A Your opportunity to talk to her will arise the next time she arrives late for work.

When she arrives late you should ask her if you could have a quiet word with her in private.

Explain that you have noticed quite a few occasions when she has been late recently and that you wondered what had caused this as you know it is out of character. Ask her if there is anything you can help with. If you have a good working relationship with her hopefully she will open up and explain the reason why.

It could be something like she no longer has a car and has to rely on public transport or that her childcare arrangements have changed. [illegible] business allows you [illegible]

[illegible] gs to

[illegible] have a career-[illegible] question for C+D? Email jrichardson@cmpmedica.com and we'll ask the experts

Springboard

Springboard Pre-registration Training Programme

The **Medway School of Pharmacy**, in partnership with **C+D**, is launching **Springboard**, an exciting new pre-registration training programme. **Springboard** will cover all aspects of the community pharmacy experience and assist the trainee in making a smooth transition from student to professional.

The programme will consist of eight in-house study days covering:

- Responding to symptoms
- Law and Ethics
- Controlled Drug regulations
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- Drug Tariff
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- Drug misuse
- Management
- Communication skills
- First aid
- The NHS and how it works
- Influencing your PCT
- Auditing your services
- Clinical cases using the BNF
- Practice exam questions

The programme will enable the student to meet the appropriate competences in the RPSGB pre-registration student handbook, and will offer support to pre-reg tutors. There will also be a tutor training day. Students will have access to a member of staff at the university and the university's facilities.

This programme is unique in that the students will have the opportunity to be accredited to provide medicines use reviews. Additionally students will be able to accumulate credits by completing distance learning courses included in the programme that can be put towards a postgraduate qualification.

All eight student study days and the tutor day will be held at Medway School of Pharmacy in Kent.

For more information on the **Springboard** course, complete the slip below and return to:
Pauline Sanderson, C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE

☐ **YES**, please send me more information on the **Springboard** pre-registration training programme

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Open Mike — Mike Hewitson

The not-so-secret diary of a new pharmacy owner

Mike Hewitson is a glutton for punishment. In the midst of economic downturn and with first-time fatherhood looming, he bought his first pharmacy in deepest, darkest Dorset – 100 miles from his former home in Cheltenham. In this regular column, follow Mike's fears, frustration's and step-by-step successes as the new owner of Beaminster Pharmacy.

> "When I think back to a year ago, I can't believe how little I knew about buying a pharmacy"

I always knew that I wanted to work for myself – it would be fair to say that it was my dream, as sad as that might sound. But it goes without saying that buying a business is not something that you should enter into lightly, and it caused me no end of heart- and headaches.

The process itself is very testing for a first time buyer, as it is extremely complicated and can be treacherous. Not having done it before, you don't really know what to do or when to do it. But I made my most important decision early on in the process: I got good help.

Without my professional advisors – accountant Umesh Modi (Modiplus) and lawyer Hilary D'Cruz (Ansons LLP) – I am sure I would not be in Beaminster Pharmacy today. I can't believe how little I knew about buying a pharmacy a year ago, and I can't count the number of stupid questions that these life (or at least business) savers had to answer. Both were responsible for guiding our purchase on the (all-too-many) occasions when things got bumpy. I remember Hilary terrifying the m[illegible] from the [illegible] was so glad she was on my side! [illegible] you too [illegible] making the leap into the u[illegible] of [illegible] be sure to pick the right t

Pharmacy's poster boy

The Six Nations Championship is always guaranteed to excite good-natured national passion, but one pharmacist has taken the fun to the streets. Rob Davies has hung up banners in front of his pharmacy near Maesteg in South Wales to celebrate Wales's matches in the European rugby union tournament.

Mr Davies told PostScript the banners have been embraced by the local community. He said: "The local populace love it. It's a talking point." His latest banner, a black "C'est la vie...", came after the coq gaulois of France defeated a Welsh team chasing back-to-back titles. Whether Wales win or lose their remaining games against Italy and Ireland, PostScript can't wait to see what messages festoon Mr Davies' pharmacy.

Barking mad

Some would say it's barking mad to put a pet's health ahead of your own, but PostScript has come across a study that puts a whole new spin on the old 'me or the dog' dilemma.

The study, published in the BMJ, put the fact that second-hand smoke affects animals too, to smokers with a pet, asking if that would make them quit. Around one third of participants, previously unfazed by their habit, said they would try to give up to save their animal companion.

PostScript predicts this study could be a useful angle for pharmacy smoking cessation services. With the number of pet owners in the country, the initiative couldn't hurt, and perhaps a puppy poster would have more impact than the deluge of medical information available... who could resist those eyes?

Web comment of the week

RPSGB's staff entertainment bill revealed
Posted by K Dhanoa on 09/03/2009, 12:47

> "I agree **staff** should be treated to improve morale, but not when it's **excessive** and when we're **picking** up the bill"

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Paracetamol tablets Reinvented

Introducing New Panadol Advance 500mg tablets, specially formulated with Optizorb™ to **disperse in the stomach up to 5 times faster** than ordinary paracetamol.[1] For mild to moderate pain relief, it may quickly achieve pole position in your pharmacy.

Product Information. Panadol Advance 500 mg Tablets (paracetamol). Contains disintegrant system to accelerate dissolution. **Uses:** Mild analgesic and antipyretic. **Dosage and administration:** *Adults and children, 12 years and over:* Two tablets at ≥ 4 hour intervals. Max. 8 tablets in 24 hours. *Children 6-12 years:* Half to one tablet at ≥ 4 hour intervals. Max. 4 tablets in 24 hours. Do not use for >3 days without doctors advice. *Children under 6 years:* Not recommended. **Contraindications:** Hypersensitivity. **Precautions:** Severe renal/hepatic impairment, non-cirrhotic alcoholic liver disease. Concomitant use of warfarin/other coumarin anticoagulants, domperidone, metoclopramide, colestyramine. Refer to doctor if persistent headache or non-serious arthritis requiring daily analgesia. **Pregnancy/breastfeeding:** *Pregnancy:* Refer to doctor. *Breastfeeding.* Not contraindicated. **Side effects:** Hypersensitivity including skin rash, blood dyscrasias. **Overdosage:** Immediate medical advice due to risk of delayed, serious liver damage. **Legal category:** 16's GSL, 32's P. **Product licence number:** PL 00071/0441. **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** Compack 16's £1.42, 32's £2.73. **Date of last revision:** February 2009. **Panadol** is a trade mark of the GlaxoSmithKline group of companies.

Reference:
1. Wilson C *et al.* Abstract PH 217, International Association for the study of Pain 12th World Congress on Pain, Glasgow, Aug 2008.

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*In the stomach

gsk GlaxoSmithKline Consumer Healthcare